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PROCEEDINGS

OF THE

MEDICAL SOCIETY

OF

LONDON.

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VOL. III.

1875–1877.

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PREFACE.

THE third volume of 'Proceedings of the Medical Society of London' records the work of the Society from the 103rd, to the 105th years of its life, and gives evidence, it is hoped, of the Society's sustained vitality and usefulness. The preparation of the volume has entailed on the Honorary Secretaries, Dr. Clement Godson and Mr. J. A. Bloxam, a considerable amount of labour, which has been undertaken with the cordiality that is traditional to their office. The List of Fellows has been carefully revised.

GEORGE BUCHANAN, *President.*

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Subject for the Fothergillian Gold Medal for March, 1878: "The Antagonistic Action of Therapeutic Agents." For March, 1879: "General Paralysis of the Insane."

N.B.—Essays competing for the prizes are to be sent in before the 1st day of the preceding November.

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1780 T. ANTHONY FOTHERGILL, M.D., F.R.S. ... £500

1807 NATHANIEL HULME, M.D. £50

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	ELECTED
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NATHANIEL HULME, M.D.	1776
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SAMUEL F. SIMMONS, M.D.	1780
JOHN SIMS, M.D.	1783
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JOSEPH ADAM, M.D.	1815
THOMAS WALSHEMAN, M.D.	1817
HENRY CLUTTERBUCK, M.D.	1819
DAVID UWINS, M.D.	1821
WILLIAM SHEARMAN, M.D.	1823
HENRY CLUTTERBUCK, M.D.	1825
JOHN HASLAM, M.D.	1827
THOMAS CALLAWAY	1829
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THOMAS E. BRYANT	1837
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GEORGE PILCHER	1842
THEOPHILUS THOMPSON, M.D.	1844
WALTER COOPER DENDY	1846
HENRY HANCOCK	1848
JOHN RISDON BENNETT, M.D.	1850

	ELECTED
E. W. MURPHY, M.D.	1851
JOHN BISHOP, F.R.S.	1852
FORBES WINSLOW, M.D., D.C.L.	1853
EDWARD HEADLAND	1854
JOHN SNOW, M.D.	1855
W. D. CHOWNE, M.D.	1856
FRANCIS HIRD	1857
W. H. WILLSHIRE, M.D.	1858
JOHN HILTON, F.R.S.	1859
ALFRED B. GARROD, M.D.	1860
WILLIAM COULSON	1861
FRANCIS SIBSON, M.D., F.R.S.	1862
EDWIN CANTON	1863
ROBERT GREENHALGH, M.D.	1864
I. B. BROWN	1865
CHARLES J. HARE, M.D.	1866
HENRY SMITH	1867
BENJAMIN W. RICHARDSON, M.D., F.R.S. ...	1868
PETER MARSHALL	1869
JOHN GAY	1870
ANDREW CLARK, M.D.	1871
THOMAS BRYANT	1872
S. O. HABERSHON, M.D.	1873
VICTOR DE MÉRIC	1874
C. H. F. ROUTH, M.D.	1875
WILLIAM ADAMS	1876

Medical Society of London.

11, CHANDOS STREET, CAVENDISH SQUARE, W.

INSTITUTED 1773.

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All the above constitute the Council of the Society.

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W. E. POOLE.

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SUBJECT:—*"On Pyæmia."*

For March, 1877.

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* Elected by the Council in accordance with revised law.

Committee for the Adjudication of the Fothergillian Gold Medal.

SUBJECT:—"*The Antagonistic Action of Therapeutic Agents.*"

For March, 1878.

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Past Lettsomian Lecturers.

(THE LETTSOMIAN LECTURES COMMENCED IN 1851.)

SESSION	
1850-51	G. Owen Rees, M.D., F.R.S., "On some of the Pathological Conditions of the Urine." G. J. Guthrie, F.R.S., "On some of the more Important Points of Surgery."
1851-52	Forbes Winslow, M.D., "On Medico-legal Evidence in Cases of Insanity." Henry Hancock, F.R.C.S., "On the Anatomy and Physiology of the Male Urethra, and on the Pathology of Stricture of that Canal."
1853-54	E. W. Murphy, M.D., "On Parturition as Illustrating the Importance of a Competent Education in the Practice of Midwifery."
1854-55	Theophilus Thompson, M.D., "On Pulmonary Consumption." John Bishop, F.R.S., "On the Physical Constitution, Diseases and Fractures of Bones."
1854-55	Francis Sibson, M.D., F.R.S., "On the Influence of the Nervous System on Respiration and Circulation." Francis Hird, "On some Special Points in the Anatomy of the Uterus, and its Structural Lesions the result of Inflammation."
1855-56	None.
1856-57	Alfred B. Garrod, M.D., F.R.C.P., "Illustrations of the Pathology and Treatment of Gout."
1857-58	Robert Barnes, M.D., "On the Physiology and Treatment of Flooding from Unnatural Position of the Placenta." Edwin Lankester, M.D., "On the History, Symptoms, and Treatment of Intestinal and other Worms Parasitic on the Human Body."
1858-59	Fredk. Headland, M.D., "On the Advance during Modern Times of the Science of Medical Treatment." Victor de Méric, "On Syphilis."
1859-60	F.W. Pavy, M.D., F.R.S., "On Certain Points connected with Diabetes." Andrew Clark, M.D., "On Certain Evidences of the Arrestment of Phthisis."
1860-61	C. J. Hare, M.D., "Practical Observations on some of the Points of Difficulty in the Investigation of Tumours and Intumescence of the Abdomen." Haynes Walton, "On the Application of the Ophthalmoscope, and its Advantages."

SESSION	
1861-62	B. W. Richardson, M.D., F.R.S., "On certain of the Phenomena of Life." F. W. Mackenzie, M.D., "On the Pathology and Treatment of Phlegmasia Dolens."
1862-63	Henry Thompson, "On Practical Lithotomy and Lithotrity." James Bird, M.D., "On Public and Private Hygiene."
1863-64	Thomas Bryant, "On the Surgical Diseases of Children." C. H. F. Routh, M.D., "On some Points connected with the Pathology, Differential Diagnosis, and Treatment of Fibrous Tumours of the Uterus."
1864-65	Henry Smith, "On the Surgery of the Rectum." J. L. W. Thudichum, M.D., "On Medicine: the Progress of Urology, with Practical Illustrations of its Value in the Diagnosis and Treatment of several Diseases."
1865-66	F. E. Anstie, M.D., "On certain Painful Affections of the Fifth Nerve."
1866-67	John Gay, "On Varicose Diseases and Ulcers of the Lower Extremities."
1867-68	George Buchanan, M.D., "On the Diagnosis and Management of Lung Diseases in Children."
1868-69	William Adams, "On Rheumatic and Strumous Diseases of the Joints, and the Treatment for the Restoration of Motion in Partial Ankylosis."
1869-70	Tilbury Fox, M.D., "Eczema: its Nature and Treatment."
1870-71	Fred. J. Gant, "On Excisional Surgery of the Joints; the Conditions appropriate for Excision; the Operations; After-Treatment and Results."
1871-72	S. O. Habershon, M.D., "On the Pathology and Treatment of some Diseases of the Liver."
1872-73	Henry Lee, "Urethral Discharges."
1873-74	W. H. Broadbent, M.D., "On Syphilitic Affections of the Nervous System."
1874-75	C. F. Maunder, "On the Surgery of the Arteries."
1875-76	C. T. Williams, M.D., "The Influence of Climate in the Treatment of Pulmonary Consumption."
1876-77.	Alfred Wiltshire, M.D., "On Vascular Rhythm as exemplified in Periodical Hæmorrhages, General and Local; and on the Treatment of Hæmorrhages from the Female Generative Organs."

The Orators.

Elected.	
1774	Dr. John Sims.
1776	Dr. David Millar.
1777	Dr. Nathaniel Hulme.
1778	Dr. John C. Lettsom.
1779	Dr. E. Edwards.
1780	Dr. Koystraa.
1781	Dr. Simmons.
1782	Dr. Wood.
1783	Dr. John Sims (2nd).
1784	Dr. Whitehead.
1785	Dr. Ralph.
1786	———
1787	Mr. Hooper.
1788	Dr. Meyer.
1789	Dr. Dennison.
1790	Dr. Wallis.
1791	Dr. Sutton.
1792	Dr. Fryer.
1793	Dr. Jameson.
1794	Dr. Gilbert Thompson.
1795	John Abernethy.
1796	Dr. J. C. Lettsom (2nd).
1797	Mr. Ware.
1798	Dr. Ferris.
1799	Mr. Ford.
1800	Dr. Bradley.
1801	Mr. Chamberlain.
1802	Dr. John Sims (3rd).
1803	Mr. Andræ.
1804	Dr. J. C. Lettsom (3rd).
1805	Dr. Pinckhard.
1806	Mr. Field.
1807	Dr. Joseph Adams.
1808	Mr. John Mason Good.
1809	Dr. Meyer Walker.
1810	Dr. Birkbeck.

Elected.	
1811	Mr. Blair.
1812	Dr. Temple.
1813	Mr. Saumarez.
1814	Dr. Rees.
1815	Mr. Taunton.
1816	Dr. Clutterbuck.
1817	Mr. Stevenson.
1818	Mr. David Uwins.
1819	Mr. Pettigrew.
1820	Dr. Hancock.
1821	Mr. Callaway.
1822	Dr. Copland.
1823	Mr. Grainger.
1824	Dr. G. Smith.
1825	Mr. Lloyd.
1826	Dr. Haslam.
1827	Mr. Kingdon.
1828	Dr. Burne.
1829	Mr. W. G. Jones.
1830	Dr. Leonard Stewart.
1831	Mr. Gossett.
1832	Dr. Whiting.
1833	F. Salmon.
1834	Dr. Shearman.
1835	Mr. W. C. Dendy.
1836	Dr. Blicke.
1837	Edward Headland.
1838	Dr. Theophilus Thompson.
1839	Geo. Pilcher.
1840	Dr. Risdon Bennett.
1841	Dr. W. D. Chowne.
1842	H. Hancock.
1843	Dr. Leonard Stewart.
1844	Thomas Bell.
1845	Dr. Marshall Hall.
1846	John Bishop.

Elected	
1847	Dr. Golding Bird.
1848	Francis Hird.
1849	Dr. Willshire.
1850	Francis Hird.
1851	Dr. Rowland.
1852	Edwin Canton.
1853	Dr. John Snow.
1854	Henry Smith.
1855	J. F. Clarke.
1856	Dr. B. W. Richardson.
1857	William Adams.
1858	Dr. A. B. Garrod.
1859	Dr. C. H. F. Routh.
1860	John Gay.
1861	Dr. Arthur Leared.
1862	Victor de Méric.

Elected	
1863	Dr. S. O. Habershon.
1864	Dr. J. L. W. Thudichum.
1865	Dr. Robert Greenhalgh.
1866	Weeden Cooke.
1867	Dr. F. W. Headland.
1868	W. F. Teevan.
1869	Sir D. Gibb.
1870	Francis Mason.
1871	Dr. William Cholmeley.
1872	Fred. J. Gant.
1873	Dr. John Cockle.
1874	R. Brudenell Carter.
1875	Dr. George Buchanan.
1876	Erasmus Wilson.
1877	Dr. J. Hughlings Jackson.

Past Fothergillian Gold Medallists.

1787	W. Falconer, M.D.
1790	R. Wellan, M.D.
1791	J. C. Lettsom, M.D.
1795	J. Mason Good.
1801	E. Bouttatz, M.D.
1803	E. Jenner, M.D.
1824	R. W. Bampfield.
1828	J. G. Perry.
1831	W. A. Guy.
1834	W. J. Clement.
1835	G. Moore.
1836	T. E. Bryant.
1838	G. Pilcher.
1840	T. Osborn.
1842	J. R. Bennett, M.D.
1843	J. C. Lerow, M.D.
1844	H. P. Robarts.
1845	W. C. Dendy.
1846	R. M. Glover, M.D.
1847	R. Stedman.
1849	J. Milligan.
1851	R. P. Cotton, M.D.
1851	R. Hodges.
1852	F. W. Headland, B.D.
1853	A. Poland.
1854	B. W. Richardson.
1856	W. Burke Ryan, M.B.
1857	E. Canton, F.R.C.S.
1858	T. H. Barker, M.D.
1859	A. T. H. Waters.
1868	John Clay.
1870	T. S. Clouston, M.D.
1872	Edwards Crisp, M.D.
1874	J. K. Spender, M.D.
1876	P. M. Braidwood, M.D.

Honorary Fellows.

Ashburner, J., M.D. (1825), 7, Hyde-park-place, W. P.

Bennett, J. Risdon, M.D. (1837; FM 1842), 22, Cavendish-square, W., President of the Royal College of Physicians; Consulting Physician to St. Thomas's Hospital, and to the Victoria-park Hospital. P 2, VP 2, C 7, O, S 3, ‡ 8.

Burrows, Sir George, Bart., M.D., D.C.L., F.R.S. (1873), 18, Cavendish-square, W., Physician in Ordinary to H.M. the Queen; Consulting Physician to St. Bartholomew's Hospital; Member of the Senate of the University of London.

Chauveau, Professor (1873), Lyons.

Christison, Sir Robert, Bart., M.D., D.C.L., LL.D. (1873), 40, Moray-street, Edinburgh, Physician in Ordinary to H.M. the Queen, in Scotland; President of the Royal Society of Edinburgh; Professor of Materia Medica in the University of Edinburgh.

Farre, Arthur, M.D., F.R.S. (1873), 12, Hertford-street, Mayfair, W., Physician-Extraordinary to H.M. the Queen; Physician-Accoucheur to H.R.H. the Princess of Wales, and H.I.R.H. the Duchess of Edinburgh.

Gueneau de Mussy, Noel, M.D. (1873), Rue St. Arnaud, Paris.

Hancock, Henry, F.R.C.S. (1838), Standen House, Chute, Wilts, Consulting Surgeon to Charing Cross Hospital. P 4, VP 5, C 8, LL, O, T 8, ‡ 14.

Hare, Charles J., M.D., F.R.C.P. (1869), 57, Brook-street, W., late Professor of Clinical Medicine in University College, and Physician to University College Hospital, &c. P, VP 2, C 8, LL, ‡ 9, ‖ 2. (*Trustee.*)

Hawkins, Cæsar, F.R.S. (1848), 26, Grosvenor-street, Sergeant-Surgeon to H.M. the Queen, and Consulting Surgeon to St. George's Hospital. C 2, S.

Hawkins, F., M.D., F.R.C.P. (1848), 16, Ashley-place, Victoria-street, S.W., Physician to the Queen's Household.

Hebra, Ferdinand, M.D. (1873), Professor of Dermatology in the University of Vienna.

Helmholtz, H., M.D. (1873), Berlin, Professor of Physiology in the University of Berlin.

*Hilton, John, F.R.S., F.R.C.S. (1845), 10, New Broad-street, E.C., Surgeon-Extraordinary to H.M. the Queen; Consulting Surgeon to Guy's Hospital and Victoria Park Hospital. P, VP, C 3, ‡ 2, SM.

HUXLEY, THOMAS HENRY, LL.D., F.R.S. (1873), 4, Marlborough-place, St. John's Wood, N.W., Professor of Natural History in the Royal School of Mines.

JENNER, Sir WILLIAM, Bart., M.D., K.C.B., D.C.L., F.R.S. (1875), 63, Brook-street, W., Physician-in-Ordinary to H.M. the Queen and to H.R.H. the Prince of Wales; Professor of Clinical Medicine in University College, London; and Physician to University College Hospital.

JOHNSTONE, H. J. W., F.R.C.S. (1843), 8, Suffolk-place, Pall-mall East.

LANGENBECK, BERNHARD VON, M.D. (1873), Berlin, Professor of Surgery in the University of Berlin.

MARSON, J. F., F.R.C.S. (1877), Highgate, N.

OLLIER, Professor (1875), Lyons.

OWEN, RICHARD, C.B., D.C.L., LL.D., F.R.S. (1873), Sheen Lodge, Richmond, Superintendent of the Natural History Department of the British Museum.

PAGET, Sir JAMES, Bart., D.C.L., LL.D., F.R.S. (1873), 1, Harewood-place, Hanover-square, W., Sergeant-Surgeon-Extraordinary to H.M. the Queen; Surgeon to H.R.H. the Prince of Wales; Consulting Surgeon to St. Bartholomew's Hospital; Member of the Senate of the University of London.

QUAIN, RICHARD, F.R.S., F.R.C.S. (1837), 32, Cavendish-square, Surgeon-Extraordinary to the Queen; Member of the General Medical Council for the College of Surgeons; Emeritus Professor of Clinical Surgery, University College. VP, C.

ROKITANSKY, CARL, M.D. (1873), Vienna, Curator of the Imperial Pathological Museum, and Professor of the University of Vienna.

SCANZONI, F. W. VON, M.D. (1873), Wurzburg, Professor of Midwifery in the University, Wurzburg.

SEAONE, M., M.D. (1835), Salamanca.

SMITH, J. GREGORY, F.R.C.S., 23, Gloucester-place, Greenwich, S.E. VP, C 4.

STOKES, WILLIAM, M.D., D.C.L., LL.D., F.R.S. (1873), 5, Merrion-square, Dublin, Regius Professor of Physic in Dublin University.

TYNDALL, JOHN, LL.D., F.R.S. (1873), Professor of Natural Philosophy in the Royal Institution, Albemarle-street, Piccadilly, W.

VIRCHOW, RUDOLPH, M.D. (1873), Berlin, Professor of Pathological Anatomy in the University of Berlin.

WILLIAMS, C. J. B., M.D., F.R.C.P., F.R.S. (1838), 47, Upper Brook-street, W., Physician-Extraordinary to H.M. the Queen; Senior Consulting Physician to the Brompton Hospital for Consumption. || 2.

Corresponding Fellows.

Elected

1851 Albaro, Sir D. J. Mendez, Madrid.
1861 Alvarengo, Pedro Francisco da Costa, M.D., Lisbon.
1856 Baker, Albert, M.D., Dawlish, Devonshire, Physician to the Dawlish Dispensary.
1855 Beardsley, A., Bay Villa, Grange, Lancashire. ||.
1850 Benavente, Sr. D. Mariano, Madrid.
Beneke, F. W., M.D., New York.
1865 Boeck, Professor, Christiania.
1850 Böhm, —, M.D., Vienna.
—— Bottani, Giuseppe, M.D., Milan.
—— Brander, J., M.D., India; in London, East India Club, St. James's-square.
1865 Braun, Professor Carl, Vienna, Physician to the General Lying-in Hospital.
1837 Bühring, J. J., M.D., Berlin.
1850 Burke, J. Page, M.D., Staff Surgeon, R.N.
1874 Burness, A. G., M.D., Port Elizabeth, Cape of Good Hope.
—— Cade, Thomas Charles, Spondon, Derby
1855 Clark, Alfred, Twickenham.
1855 Coates, Charles, M.D., 10, Circus, Bath, Physician, Bath Royal United Hospital. c 3, ‡ 2, || 3.
1850 Cox, William I., Hawkesbury Upton, Gloucestershire. c.
1850 Curtis, George, Dorking.
1851 Cutler, Edw., M.A., Spa, Belgium.
1851 Czermak, John, M.D., Prague, Professor of Anatomy and Physiology.
1876 Dawes, R. S., Gawler, South Australia.
—— De Muynck, J., M.D., Ghent.
1865 Diday, Paul, M.D., Lyons.
1836 De Sa, Manoel Carvalho Pereira, M.D., Rio Janeiro.
—— Ekstein, Sigismund, M.D., Vienna.
1851 Escolor, Sr. D. Serapio, Madrid.
—— Eylandt, Johann Emil, M.D., Curland, Russia.
1865 Falconer, Randle Wilbraham, M.D., F.R.C.P., 22, Bennett-street, Bath, Consulting Physician to the Royal United and Mineral Water Hospitals.
1853 Fallot, R., M.D., St. Laurant d'Aigonze, Montpelier, France.
1864 Fedeti, G., M.D., Rome.
1851 Flor, Sr. D. Jose Perez, Madrid.

Elected

1876 Griffith, R. Glyn, Dinapore, India.
—— Harding, George, East Indies, 37th Native Infantry, E.I.C.
1864 Hasenfeld, Emmanuel, M.D., Pesth.
1867 Hughes, J. S., M.D., Dublin.
—— Hughes, Robert, F.R.C.S., Barnstaple, Devon.
—— Hyman, —, M.D., Antwerp.
1851 Iiguierdo, Sr. D. Sebastian Obtega, Madrid.
—— Jackson, J. M., Madras, E.I.C. Madras Light Infantry.
—— Jeyes, Samuel, M.D., Half-pay Staff.
1875 Jones, P. Sydney, M.D., College-street, Sydney, Australia.
1861 Journez, Henri, M.D., 43, Rue de la Charité, Bruxelles, Belgique.
1852 Junod, Theodore, M.D., Geneva.
—— Kitching, G., M.D., Enfield.
1851 Kölliker, Albert, M.D., Wurzburg, Professor of Anatomy and Physiology.
—— Lax, William, Ormskirk, Lancashire, Surgeon to the Ormskirk Dispensary.
1876 Leighton, Walter H., M.D., Lowell, Massachusetts, U. S. America.
—— Leon, Sr. D. Jose, Madrid.
1851 Llanos, Sr. Antonio Campo, Madrid.
1851 Lovera, Sr. D. Jose, Madrid.
1851 Marino, Sr. D. Bonifacio Mateos, Madrid.
1851 Mendez, Sr. D. Bartholome, Madrid.
1851 Molina, Sr. D. M. M., Madrid.
—— Moore, George, M.D. (fm 1834), Hastings. ‡ 2.
—— Nash, James, M.D., High-street, Worcester, Consulting Physician to the Worcester Infirmary.
—— Nefri, Gaetano, M.D., Pisa.
1851 Ortega, Sr. D. J. R., Madrid.
1865 Peruzzi, Domenico, M.D., Senigaglia.
1851 Portilla, Sr. D. L. Luis, Madrid.
1860 Roussell, Dr., Dean of Faculty and Medicine at Montpelier.
—— Scharlau, Gus. W., M.D., Stettin, Prussia.
1876 Schmitz, Richard, M.D., Neuenahr.
1874 Schutgowsky, J., St. Petersburg.
1854 Seaton, Jos. M.D., F.R.C.P. (Edin.), F.R.G.S., Halliford House, Sunbury. ‡ 5.
1851 Sesse, Sr. D. M., Mesqui, Madrid.
—— Stockwell, Thomas G., F.R.C.S., 9, Alfred-street, Bath.
—— Stolterforth, Sigismund, M.D., F.R.C.P., Queen's-park, Chester.
1851 Tereza, Sr. L. Felix Garcia, Madrid.
—— Terry, H., Northampton.
1851 Valdez, Sr. D. Franco Cortigo, Madrid.
—— Williams, Charles, F.R.C.S. Edin., 9, Prince of Wales-road, Norwich.
—— Wilson, Charles, M.D., Dalrymple Crescent, Grange, Edinburgh.

GENERAL LIST OF FELLOWS OF THE SOCIETY.

EXPLANATION OF ABBREVIATIONS.

P.—President.
VP.—Vice-President.
T.—Treasurer.
L.—Librarian.
S.—Secretary.
C.—Councillor.
LL.—Lettsomian Lecturer.
FM.—Fothergillian Gold Medallist.
SM.—Silver Medallist.
O.—Orator.
§—Sec. for Foreign Correspondence.
‡—Steward.
*—Life Members.
‖—Conversazione Steward.

The number prefixed (*e.g.* 1853) signifies the date of election.

The figures appended (*e.g.* s 2, c 3) indicate the number of Sessions served, and refer to past appointments ONLY.

NS.—Non-subscribing.

Elected

1873 ADAMS, M. A., F.R.C.S., Maidstone, Kent.

1872 ADAMS, T. RUTHERFORD, M.D., Stamford House, Croydon, Surgeon to the Croydon General Hospital. ‖.

1852 ADAMS, WILLIAM, F.R.C.S., Surgeon to the Great Northern Hospital, 5, Henrietta-street, Cavendish-square, W. (*Councillor.*) c 6, o 10, VP. 3, ‖ 1, LL, P, ‡ 6.

1868 AITKEN, WM., M.D., F.R.S., Woolston, Southampton, Professor of Pathology, Army Medical School, Netley. ‖. NS. ‡.

1872 ALDRED, HENRY ALLEN, M.D., 7, Albemarle-street. ‡.

1873 ALLEN, H. MARCUS, M.R.C.P. Edin., 38, Regency-square, Brighton. ‡.

1873 ALLFREY, C. H., M.D., F.R.C.S., St. Mary's Cray, Chislehurst, Kent. ‖.

1872 ALLINGHAM, WILLIAM, F.R.C.S., 25, Grosvenor-street, Grosvenor-square, W., Surgeon to St. Mark's Hospital. (*Councillor*), ‡ 3.

1860 ALTHAUS, JULIUS, M.D., 18, Bryanston-street, Portman-square, W., Senior Physician to the Hospital for Epilepsy and Paralysis, Regent's Park. c 5, ‡ 1, §.

1871 AMBLER, VINCENT, 14, Colville-square, Bayswater, W. ‖ 4, ‡.

1868 AMSTRONG, JOHN, M.D., Dartford. NS.

1868 ARMSTRONG, JOHN CHRISTOPHER, Gravesend. NS.

Elected

1871 Arnold, Wilberforce, Belfast. ns.

1867 Aspray, Charles Owen, M.D., F.R.C.S., 4, Devonshire-street, Portland-place, W., Surgeon to the Western Dispensary for Diseases of the Skin.

1873 Atkinson, Edward, 36, Albion-street, Leeds, Surgeon to the Leeds General Infirmary, and Lecturer on Surgery to the Leeds School of Medicine.

1872 Aveling, James H., M.D., 1, Upper Wimple-street, W., Physician to the Chelsea Hospital for Women. ‡.

1873 Bagshawe, Frederic, M.A., M.D., 5, Warrior-square, St. Leonards, Assistant Physician to the East Sussex Infirmary. ‡.

1871 Bailey, George H., 9, Cavendish-place, W., Chloroformist to the Cancer Hospital and Dental Hospital.

1873 Bailey, James J., M.D., Marple, Cheshire.

1859 Barnes, J. Wickham, F.R.C.S., 3, Bolt-court, E.C. ‡ 5, c 3, s 2, ||.

1876 Barnes, R. S. Fancourt, M.B., 39, Weymouth-street, W., Physician to the British Lying-in Hospital, and Physician-Accoucheur to the St. George and St. James's Dispensary.

1871 Barry, D. Paterson, M.D., Twickenham. ns.

1874 Barrett, Howard, 3, Tavistock-square, W.C.

1874 Bartlett, Joseph James Henry, 35, Ladbroke-gardens, Notting-hill, Surgeon to Kensington Dispensary.

1868 Bateman, Frederic, M.D., F.R.C.P., Upper St. Giles-street, Norwich, Physician to Norwich and Norfolk Hospital. ns.

1868 Beatty, Thomas Carlyle, Seaham, Sunderland. ns.

1868 Bell, The Rev. David, M.D., M.A., The Vicarage, Goole, Yorkshire. ||, c 3.

1867 Bell, H. Royes, F.R.C.S., 44, Harley-street, W., Assistant Surgeon to King's College Hospital. || 5, ‡ 7, c 3 (*Councillor*), s, vp, sm.

1872 Bell, John H., M.D., Northampton. ns.

1872 Berkart, I. B., M.R.C.P., 71, Wimpole-street, W., Assistant Physician to the City of London Hospital for Diseases of the Chest.

1873 Beveridge, J. Spowart, M.R.C.P. Ed., 15, Palace-gardens-terrace, Kensington, W.

1868 Bird, Geo., M.D., 49, Welbeck-street.

1850 *Birkett, John, F.R.C.S., 59, Green-street, Grosvenor-square, W. vp, c 6, ‡ 2, ||.

1860 Blower, William, Bedford. ns.

1871 Bloxam, John Astley, F.R.C.S., 8, George-street, Hanover-square, W., Assistant Surgeon to the Charing Cross and Surgeon to the Lock Hospitals. ||, 2, ‡ 2 (*Hon. Sec.*).

1868 Bloxam, William, M.D., 21, Mount-street, W. || 3, 2 ‡, c 2.

1867 Bond, Thomas, M.B., B.S., F.R.C.S., 50, Parliament-street, S.W., Assistant Surgeon to Westminster Hospital. (*Councillor.*)

Elected

1864 Bonney, F. A. Burdett, Elm House Asylum, 149, Church-street, Chelsea, S.W. ‡ 2, || 2.

1871 Bothwell, G. G., Leighton Buzzard, Bedfordshire. ns.

1872 Boulton, Percy, M.D., 6, Seymour-street, Portman-square, W., Physician to the Samaritan Hospital.

1871 Boyd, Robert, M.D., F.R.C.P., 1, Bolton-row, W. ‡ 3.

1868 Brady, John, M.P., M.R.C.P., Ely, Cambs.

1868 Braidwood, P. M., M.D., Birkenhead. fm 1877, ns.

1869 Braine, Woodhouse, F.R.C.S., 56, Maddox-street, W., Chloroformist to Charing Cross Hospital and Dental Hospital. s 2, c, || 5, ‡ 6, sm (*Vice-President*).

1876 Brewer, Alex. Hampton, 201, Queen's-road, Dalston, E.

1873 Bridgwater, Thomas, M.B., Medical Officer of the Harrow Dispensary. ‡.

1863 Broadbent, W. H., M.D., F.R.C.P., 34, Seymour-street, Portman-square, W., Physician to St. Mary's and London Fever Hospitals; Lecturer on Medicine, St. Mary's Hospital Medical School. ‡ 4, c 4, || 4, ll, vp.

1871 Brown, John, Claremont-villa, Falcon-road, Clapham Junction, S.W.

1874 Brown, James David, F.R.C.S., Haverfordwest, Surgeon to the Infirmary.

1871 Browne, J. Crichton, M.D., 7, Cumberland-terrace, Regent's-park, N.W., Lord Chancellor's Visitor.

1873 Browne, Lennox, F.R.C.S. Ed., 36, Weymouth-street, W., Senior Surgeon to the Central London Throat and Ear Hospital, and Aural Surgeon to the Royal Society of Musicians. ‡ 3, || 2.

1873 Brunjes, Martin, 47, Edgware Road, W. ‡ 2.

1862 Brunton, John, M.A., M.D., 21, Euston-road, N.W., Examiner in Midwifery and Forensic Medicine in the University of Glasgow, Surgeon to the Royal Maternity Charity. c ‡, 6, || 2 (*Councillor*).

1874 Brunton, T. Lauder, M.D., F.R.S., 50, Welbeck-street, W., Assistant Physician and Lecturer on Materia Medica at St. Bartholomew's Hospital, Examiner in Materia Medica at the University of London. ‡ 2 (*Councillor*).

1850 Bryant, Thomas, F.R.C.S., 53, Upper Brook-street, W., Surgeon to Guy's Hospital. p, vp. 2, s 2, c 4, ll, ‡ 11, || 3.

1848 Bryant, Walter J., F.R.C.S., 23 a, Sussex-square, Hyde-park-gardens, W. || 3, ‡ 3.

1858 Buchanan, George, M.D., F.R.C.P., 24, Nottingham-place, Regent's park, Assistant Medical Officer to the Local Government Board. c 2, ll, vp, ‡ 4, || 2, o (*President*).

1868 Buckle, Fleetwood, M.D., H.M.S. *Invincible*. ns.

1876 Bucknill, John Charles, M.D., F.R.S., 39, Wimpole-street, W.

1873 Bunny, Joseph, M.D., Newbury, Berks.

1872 Burger, Alex., 6, King-street, Finsbury, Honorary Surgeon to German Hospital.

1850 Burnie, Wm., M.D., Bradford. || 2. ns.

Elected

1872 Byas, Edward, Grove Hall, Bow, E.

1850 Camps, Wm., M.D., Western-villas, Ealing. c 5, ‡ 17.

1839 Canton, Edwin, F.R.C.S. (fm. 1857), 30, Montague-place, Russell-square, W.C., Surgeon and Lecturer on Surgery at Charing-cross Hospital; Surgeon to the British Museum. p, vp 2, c 6, ll, s, o, ‡ 12, ||.

1870 Carpenter, Alfred, M.D., High-street, Croydon. || (*Orator*), c. 2.

1871 Carter, R. Brudenell, F.R.C.S., 69, Wimpole-street, W., Surgeon to Royal South London Ophthalmic Hospital; Ophthalmic Surgeon to, and Lecturer on Ophthalmic Surgery at, St. George's Hospital. o, ‡ 3, || 2.

1848 Cartwright, S., F.R.C.S., 32, Old Burlington-street, W., late Professor of Dental Surgery and Surgeon-Dentist to King's College Hospital, London; Consulting Surgeon to the Dental Hospital of London. ‡ 10.

1876 Cartwright, S. Hamilton, 32, Old Burlington-street, W., Professor of Dental Surgery at King's College, and Dental Surgeon to the Hospital; Lecturer on Dental Surgery at London School of Dental Surgery. ‡.

1876 Cathcart, Samuel, Prudhoe House, High-road, Tottenham, E.

1865 Chambers, Thos., F.R.C.P. Ed., F.R.C.S., 64, Chester-square, S.W., Senior Physician to the Chelsea Hospital for Women, and Consulting Physician-Accoucheur to the Western Dispensary, Westminster. || 2.

1867 Chapman, John, M.D., 212, Rue de Rivoli, Paris, late Assistant Physician to the Metropolitan Free Hospital. ‡ 2.

1872 Charlsley, W. P., M.D., Inspector General of Hospitals, Island of Ceylon. ns.

1868 Chessall, William, M.D., Horley, Surrey. ns.

1868 Child, Edwin, New Malden, and Coombe, Surrey. ‡ 5, || 2. ns.

1861 Cholmeley, W., M.D., F.R.C.P., 63, Grosvenor-street, W., Physician to the Great Northern Hospital, and Consulting Physician to the Margaret-street Infirmary for Consumption. c 5, ‡ 9, sm, o, §, || 3, vp.

1870 Christie, T. B., M.D., F.R.C.P., Royal India Asylum, Ealing, W. ||.

1871 Churton, Thomas, M.B., 35, Park-square, Leeds, Physician to the Leeds Public Dispensary. ||, ‡ 2.

1874 Clapton, W., F.R.C.S., 30, Queen-street, E.C., Surgeon to Royal Humane Society.

1854 Clark, Andrew, M.D., F.R.C.P., 16, Cavendish-square, W., Physician to, and Lecturer on Clinical Medicine at, the London Hospital; Consulting Physician to the East London Hospital for Children. p, vp, c 5, ll, § 6, || 5.

1875 Clark, Andrew, F.R.C.S., 19, Cavendish-place, W., Assistant Surgeon, and Surgeon to Throat and Ear Department, Middlesex Hospital.

1873 Clarke, T. Kilner, M.A., M.D., Huddersfield, Surgeon to Huddersfield Infirmary.

Elected

1870 Clouston, T. S., M.D. (FM 1870), Superintendent Royal Asylum, Edinburgh. NS.

1874 Clover, J. T., F.R.C.S., 3, Cavendish-place, W., Chloroformist to the Dental Hospital. ||.

1873 Clubbe, W. H., Lowestoft, Surgeon to Lowestoft Infirmary.

1869 Coates, William Martin, Salisbury, Surgeon to the Salisbury Infirmary. NS.

1869 Cockle, John, M.A., M.D., F.R.C.P., 7, Suffolk-place, W., and West Moulsey Lodge, Surrey, Physician to the Royal Free Hospital. VP, c 2, L 3, ‡ 5, SM, ||, o.

1848 Cogswell, C., M.D., F.L.S., 47, York-terrace, Regent's-park, N.W. s 4, ‡ 8, || 3 (*Trustee*).

1877 Colbourne, J. G., Brooklyn-villas, Wimbledon, S.W.

1867 *Coles, George Charles, 20, Great Coram-street, Russell-square, W.C. ‡ 6, || 3, c 1.

1872 Coles, J. Oakley, L.D.S., R.C.S., 5, Upper Wimpole-street, W. ‡ 3.

1853 Collambell, C., F.R.C.S., 15, Lambeth-terrace, Lambeth, S. ‡ 2, || 2.

1870 Collie, Alexander, M.D., Medical Officer to the Fever Hospital, Homerton, E. ‡.

1871 Cook, John, M.D., 3, Upper Wimpole-street, W., Senior Physician to St. Marylebone General Dispensary, and Physician to the Out-patients, Great Northern Hospital. ‡ 2.

1863 Cooper, Alfred, F.R.C.S., 9, Henrietta-street, Cavendish-square, W., Surgeon to the West London Hospital, and to Lock Hospital; Assistant Surgeon to Mark's Hospital for Fistula. || 3, c 3, ‡ 6.

1873 Cooper, Sir Henry, Kt., M.D., F.R.C.P., 9, Charlotte-street, Hull, Consulting Physician to the Hull General Infirmary. c 2.

1872 Corfield, W. H., M.A., M.D., F.R.C.P., 10, Bolton-row, Mayfair, Professor of Hygiene, &c., University College, London; Medical Officer for Health for St. George's, Hanover-square. || 2, ‡.

1851 *Cotton, R. Payne, F.R.C.P. (FM 1851), 33, Cavendish-square, W., Consulting Physician to the Hospital for Consumption and Diseases of the Chest, Brompton. c 3, ‡ 2.

1861 Coulson, Walter J., F.R.C.S., 17, Harley-street, W., Surgeon to the Lock Hospital and St. Peter's Hospital for Stone. s 2, c 3, ‡ 6.

1874 Craigie, J. H., 13, Portland-place, W. ‡.

1873 Craven, R. Martin, 14, Albion-street, Hull, Surgeon to the Hull General Infirmary.

1833 Crisp, Edwards, M.D., 16, Beaufort-street, Chelsea, S.W. SM FM 1872, c, § 3, ‡ 3.

1872 Crombie, John M., M.A., M.B., 140, Finboro'-road, West Brompton, S.W.

1855 Cross, R., M.D., F.R.C.P. Edin., 42, Craven-street, Strand, W.

1874 Cumberbatch, A. E., M.B., F.R.C.S., 7, Queen Anne-street, W., Aural Surgeon to the Great Northern Hospital. || 2.

Elected

1871 Dalby, Wm. Bartlett, B.A., M.B., F.R.C.S., 18, Savile-row, W., Aural Surgeon and Lecturer on Aural Surgery at St. George's Hospstal. ‡ (*Councillor*).

1865 Dale, G. C., M.D., F.R.C.S., Ivy Lodge, Upper Tooting, S.W. ||.

1873 Daly, Owen, M.D., F.R.C.P., 23, Albion-street, Hull, Physician to the Hull General Infirmary.

1831 *Davidson, Thomas, M.D., Shaftesbury House, Bayswater, W. VP 2, C 5, SM, ‡, § 20.

1868 *Davy, Richard, F.R.C.S., 33, Welbeck-street, W., Surgeon and Lecturer on Surgery at the Westminster Hospital. S 2, SM, ‡ 4, § 2 (*Vice-President*).

1877 Dawson, Nesbitt, M.D., 34, Cambridge-place, Hyde-park, W.

1871 Day, Henry, M.D., F.R.C.P., Stafford, Physician to the Stafford County Infirmary. NS.

1867 Day, Wm. Henry, M.D., 10, Manchester-square, Physician to the Samaritan Free Hospital for Women and Children. || 5, ‡ 6, C 3.

1871 De Ronzy, A. O. C., Lahore. NS.

1844 *Diamond, Hugh W., M.D., Twickenham House, Twickenham, Middlesex. ‡ 3.

1868 Dick, Henry, M.D., 59, Wimpole-street, W.

1871 Dickinson, James C., 8, Chapel-place, Cavendish-square.

1872 Down, J. Langdon, M.D., F.R.C.P., 39, Welbeck-street, W., and Normansfield, Hampton Wick, Physician to the London Hospital. || 2.

1871 Dowse, Thomas S., M.D., F.R.C.P. Ed., Tray's Hill Hall, Hornsey-lane, Highgate, N. ‡ 2 (*Hon. Sec. for Foreign Correspondence*).

1877 Drew, J. H., 2, Cambridge-terrace, Hyde-park, W.

1874 Drysdale, C. R., M.D., 17, Woburn-place, W.C., Senior Physician to the North London Hospital for Consumption, and Senior Physician to the Metropolitan Free Hospital.

1848 Duncan, James, M.B., 8, Henrietta-street, Covent-garden, W.C. ‡, || 4.

1874 Duncan, B. Arcedeckne, M.R.C.P. Edin., Gower-house, 88, Gower-street, W.C. ||.

1857 Dunn, R. W., 13, Surrey-street, Strand, W.C. ‡ 6, C 3, || 2.

1848 Du Pasquier, C. F., F.R.C.S., 62, Pall Mall, Surgeon Apothecary to Her Majesty; Apothecary in Ordinary to Her Majesty's Household; Surgeon Apothecary to H.R.H. Prince of Wales's Household, &c. ‡ 2, ||, C 3.

1873 Duranty, E. Nicholas, M.D., Marseilles, NS.

1873 Durham, Arthur E., F.R.C.S., 82, Brook-street, W., Surgeon and Lecturer on Surgery at Guy's Hospital. ‡.

1865 Ebsworth, Alfred, F.R.C.S., 5, Henrietta-street, Covent-garden, W.C. ‡.

1860 Edmunds, J., M.D., M.R.C.P. Lond., 5, Savile-row, W., Physician to the London Temperance Hospital; Medical Officer of Health and Public Analyst for St. James's, London. ‡ 7, || 2.

Elected

1868 Elliott, Geo. F., M.D., Hull, Physician to the Hull General Infirmary. NS.

1872 Ellis, James, Calcutta. NS.

1868 Evans, William, M.D., Belsize-park.

1877 Ewart, William, M.B., 33, Somerset-street, Portman-square, W.

1869 Farquharson, R., M.D., 23, Brook-street, Grosvenor-square, W., Physician to the Belgrave Hospital for Children, Lecturer on Materia Medica at St. Mary's Hospital. || 3, ‡ 4 (*Councillor*).

1872 Fayrer, Sir Joseph, K.C.S.I., M.D., 16, Granville-place, Portman-square, W., Honorary Physician to H.M. the Queen and H.R.H. the Prince of Wales; Physician to H.R.H. the Duke of Edinburgh. ‡ 3, || 2 (*Councillor*).

1847 Field, Wm., 224, Oxford-street, W. ‡ 7, || 2.

1876 Fisher, Frederic R., 79, Grosvenor-street, W. ‡.

1868 Fletcher, Thomas Bell, M.D., F.R.C.P., Senior Physician to the Birmingham General Hospital. NS.

1868 Folker, William Henry, F.R.C.S., Hanley, Staffordshire, Surgeon to the North Stafford Infirmary. NS.

1873 Foss, R. W., M.D., Stockton-on-Tees, Honorary Medical Officer to the Stockton Surgical Hospital.

1869 Foster, Balthazar W., M.D., F.R.C.P., 16, Temple-row, Birmingham, Physician to the General Hospital, Birmingham. NS.

1872 Fothergill, J. Milner, M.D., 23, Somerset-street, W., Assistant Physician to the West London Hospital and to the Victoria-park Chest Hospital. || 2, C (*Councillor*).

1873 Fox, A. W., M.B., 16, Gay-street, Bath, Physician to the Eastern Dispensary, Bath.

1868 Fox, Charles Henry, M.D., Brislington-house, near Bristol. NS.

1871 Fox, Francis, 1, Hamilton-terrace, Ladbroke-grove, Kensington-park, W. || 2.

1868 Fox, John M., Armaside, Cockermouth. NS.

1863 Fox, Tilbury, M.D., F.R.C.P., 14, Harley-street, W., Physician to the Department for Diseases of the Skin, University College Hospital. C, † 4, LL.

1869 Frampton, Thomas, 62, Gloucester-terrace, Hyde-park. ||.

1868 Freer, Alfred, Stourbridge. NS.

1868 Fry, Fred., F.R.C.S., Maidstone, Consulting Surgeon to the West Kent General Hospital, Maidstone. NS.

1868 Gaine, Charles, Bath, Dental Surgeon to the Royal United Hospital. NS.

1862 Gant, F. J., F.R.C.S., 16, Connaught-square, W., Surgeon to the Royal Free Hospital. || 2, ‡ 5, LL, O, C 3, VP 2.

1849 Gardner, Harry, M.D., Westbourne-terrace-villa, Westbourne-square, W. C 2.

1847 Garrod, Alfred B., M.D., F.R.C.P., F.R.S., 10, Harley-street, W., Consulting Physician to King's College Hospital. P, VP 2, C 9, O, LL, ‡ 2.

Elected

1849 GAY, JOHN, F.R.C.S., 10, Finsbury-place South, E.C., Senior Surgeon to the Great Northern Hospital; Consulting Surgeon to the Soldiers' Daughters' Home, to the Earlswood Asylum, the North London and Metropolitan Railways, to the National Provident and the Provident Clerks' Assurance Offices. P, VP, LL, C 3, O, T 6, ‡ 7, || 4 (*Councillor*).

1873 GEE, ROBERT, M.D., 5, Abercromby-square, Liverpool, Consulting Physician to the Hospital for Diseases of Chest, Liverpool.

1856 GIBBON, S., A.B., M.B., 39, Oxford-terrace, W. ‡ 2.

1867 GILL, WILLIAM, 11, Russell-square, W.C. ‡ 2.

1871 GLYNN, T. R., M.B., Liverpool, Physician to the Royal Infirmary, Liverpool. NS.

1857 GODFREY, JOHN, M.D., F.R.C.P. Edin., North Gate, Regent's-park, N.W.

1867 GODSON, CLEMENT, M.D., 8, Upper Brook-street, Grosvenor-square, W., Assistant Physician-Accoucheur to St. Bartholomew's Hospital. C 3, ‡ 6, || 6 (*Hon. Sec.*).

1872 GODSON, CHARLES, F.R.C.S., Barnet, Herts, Medical Officer to the Barnet Union. || 3, ‡ 2, NS.

1869 GOODMAN, CHARLES ROWLAND, M.D., Cheetham, Manchester. NS.

1873 GOODSALL, D. H., F.R.C.S., 34, Finsbury-square, E.C., Surgeon to the Metropolitan Free Hospital, and Assistant Surgeon to St. Mark's Hospital. ‡ 2.

1876 GOWERS, WILLIAM RICHARD, M.D., 50, Queen Anne-street, W., Assistant Physician and Teacher of Clinical Medicine at University College Hospital; Assistant Physician to the National Hospital for the Paralysed and Epileptic.

1874 GOWLLAND, P. Y., F.R.C.S., 34, Finsbury-square, E.C., Senior Surgeon to St. Mark's Hospital.

1867 GRASEMANN, C. EDWARD, M.D., 46, Albany-street, Regent's-park, N.W. || 3.

1872 GRAY, ROBERT, Indian Medical Service. NS.

1843 *GREENHALGH, ROBERT, M.D., 72, Grosvenor-street, W., Consulting Physician to the City of London Lying-in and Samaritan Hospitals; late Physician-Accoucheur and Lecturer on Midwifery and the Diseases of Women and Children, St. Bartholomew's Hospital. P, VP, O, C 5, S 3, ‡ 5.

1868 GREGSON, GEO., 26, Harley-street, Dental Surgeon to the Dental Hospital of London. ‡ 4, || 3.

1873 GRIEVE, ROBERT, M.D., New Amsterdam, B. Guiana.

1875 GRIFFITH, G. DE GORREQUER, M.D., 9, Lupus-street, Belgravia, S.W., Senior Physician to the Hospital for Women and Children, Pimlico.

1873 GRINDROD, R. B., M.D., Townsend House, Great Malvern.

1859 HABERSHON, S. O., M.D., F.R.C.P., 70, Brook-street, Senior Physician to, and Lecturer on Medicine at, Guy's Hospital. P, C 3, O, ‡ 6, || 2, LL.

1869 HADEN, W. H., M.D., 66, Harley-street. ||, ‡.

1868 HAINWORTH, JOHN, F.R.C.S., 138, Camden-road, N.W. C 3, || 4, ‡ 2.

Elected

1874 HALL, F. DE HAVILLAND, M.D., 46, Queen Anne-street, W., Assistant Physician to the Westminster Hospital. ‡.

1871 HAMILTON, ROBERT, M.D. Cantab. ||, ‡. (Travelling.)

1834 HARDING, WM., 4, Percy-street, Bedford-square, W.C. VP 2, C 3, ‡ 5, ||.

1875 HARDWICKE, HERBERT JUNIUS, M.D., F.R.C.S., Parkfield House, Sheffield.

1873 HARDWICKE, JUNIUS, F.R.C.S., Rotherham, Senior Consulting Surgeon to the Rotherham Infirmary.

1850 *HARE, CHARLES J., M.D., F.R.C.P., Hon. Fellow, *q. v.*

1865 HARPER, PHILIP H., F.R.C.S., 30, Cambridge-street, Hyde-park, W. ‡.

1871 HARRIS, CHARLES JAMES, 11, Kilburn Priory, N.W. || 2.

1872 HARRIS, HENRY, M.D., F.R.C.S., Trengweath, Redruth, Cornwall. || 2, ‡. NS.

1873 HARRIS, WM. JOHN, 13, Marine Parade, Worthing, Senior Medical Officer to the Worthing Infirmary. || 2, ‡ 2.

1851 HARRISON, C. H. ROGERS, F.R.C.S., Vine House, 55, Stockwell-road, S.W., Consulting Surgeon to St. Pancras Infirmary; Honorary Surgeon to Brixton and Stockwell Dispensary. VP 2, C 3, S 5, T 6, SM, † 21, || (*Trustee*).

1871 HARRISON, REGINALD, F.R.C.S., Liverpool. NS.

1865 HARVEY, J. A., 35, Princes-square, Bayswater, W.

1875 HASTINGS, GEORGE, M.D., 47, Kensington-park-gardens, W., Physician to the North London Consumption Hospital.

1852 HAWARD, EDWIN, M.D., 9, Harley-street, W. ‡ 3.

1852 HAWKSLEY, THOMAS, M.D., 17, Cheyne-walk, S.W., Consulting Physician to the Margaret-street Infirmary for Consumption. C 5, ‡ 2, ||.

1872 HAZEL, GEORGE, 71, Oakley-square, N.W. || 2, ‡.

1869 HEATON, JOHN DEAKIN, M.D., F.R.C.P., Leeds, Senior Physician to the Leeds General Infirmary. || 4. NS (*Councillor*).

1871 HEMMING, W. B., 26, Notting-hill-terrace, W., Consulting Surgeon to the Notting-hill and Shepherd's-bush Dispensary. ‡, || 2.

1876 HEMMING, W. DOUGLAS, 26, Notting-hill-terrace, W.

1853 HENRY, A., M.D., 57, Doughty-street, W.C. C 7, ‡ 4.

1876 HEYCOCK, F. R., M.D., F.R.C.S., 16A, Old Cavendish-street, W., Assistant Surgeon to St. Peter's Hospital. ‡.

1872 HICKS, JOHN BRAXTON, M.D., F.R.C.P., F.R.S., 24, George-street, Hanover-square, Physician-Accoucheur and Lecturer on Midwifery and Diseases of Women and Children, Guy's Hospital. || 2, ‡.

1868 HILL, R. GARDINER, Res. Phys., Earl's Court House, Old Brompton. S 2, ‡, ||.

1867 HILL, THOS. HARVEY, 4, Stanhope-terrace, Bayswater. ‡ 8, || 5, C 3 (*Treasurer*).

1845 HILTON, JOHN, F.R.S., F.R.C.S., Hon. Fellow, *q. v.*

1840 HIRD, FRANCIS, F.R.C.S., 13, Old Burlington-street, W., Surgeon to Charing-cross Hospital. P 2, VP 6, C 12, LL, O 2, ‡ 20 (*Trustee*).

1877 HOAR, WILLIAM, Maidstone, Consulting Surgeon to the West Kent General Hospital.

Elected

1873 Hobson, W. H., Great Berkhampstead, Herts, Honorary Surgeon to the West Herts Infirmary.

1873 Hodge, B. Terry, Sidmouth, Devon.

1848 Hogg, Jabez, 1, Bedford-square, W.C., Surgeon to the Royal Westminster Ophthalmic Hospital. VP, C 2, ‡ 9, ‖ 2.

1868 Holman, Constantine, M.D., Reigate. ‡ 3, ‖ 2 (*Councillor*).

1875 Hope, William, M.D., 5, Bolton-row, Mayfair, W., Senior Physician to Queen Charlotte's Lying-in Hospital, and Physician to Belgrave Hospital for Children.

1865 Hume, F. H., 58, Devonshire-street, Islington, N. ‡.

1874 Husband, H. Aubrey, M.B., Bentinck House, Stroud-green-road, Finsbury-park, N.

1833 Hutchinson, F., M.D., F.R.C.S., 29, Woburn-place, Russell-square, W.C. C 13, ‡ 9.

1874 Hutchinson, S. J., 44, Brook-street, W.

1869 Irwin, W. C., M.D., Leicester. NS.

1868 Jackson, J. Hughlings, M.D., F.R.C.P., 3, Manchester-square, W., Physician to the London Hospital and to the Hospital for Epilepsy and Paralysis. O, C 2.

1853 Jackson, R., M.D., 53, Notting-hill-square, W.

1871 Jackson, T. Carr, F.R.C.S., 91, Harley-street, W., Surgeon to the Great Northern Hospital, and to the National Orthopædic Hospital. ‖ 2.

1875 Jagielski, Apollinaris Victor, M.D., M.R.C.P. Lond., 20, Weymouth-street, Portland-place, W., Honorary Physician to the Infirmary for Consumption. ‡.

1856 Jephson, J. H., M.D., 20, Warwick-gardens, Kensington, W., late Physician to the Great Northern Hospital. C 2, ‡ 4.

1873 Johnson, J. S., High-street, Croydon, Surgeon to the Croydon Dispensary.

1875 Jones, Sydney, M.B., F.R.C.S., 10B, St. Thomas's-street, S.E., Surgeon and Lecturer on Surgery at St. Thomas's Hospital.

1875 Jones, Walter, M.D., 45, Finsbury-square, E.C.

1876 Juler, H. E., Resident Registrar to St. Mary's Hospital, Paddington, W.

1874 Kavanagh, Patrick, M.D., Lorne House, Wickham-road, Lewisham road, S.E.

1874 Keene, James, F.R.C.S., 59, Brook-street, W., Assistant Surgeon and Lecturer on Aural Surgery to the Westminster Hospital, and Surgeon to the Central London Ophthalmic Hospital. ‡.

1847 Kellock, W. Berry, Stamford-hill, N. ‖ 2, ‡.

1873 Kempthorne, John, F.R.C.S., Callington, Cornwall.

1876 Key, A. C., 30, Wilton-place, S.W.

1866 King, M. Kelburne, M.D., F.R.C.S., Hull, Surgeon to the Hull General Infirmary. NS.

1868 Kirkman, Wm. P., M.D., St. Leonard's-on-Sea. ‖ 2, ‡. NS.

Elected

1860 Kitching, John, M.D., Heworth's Cottage, York. NS.

1868 Knaggs, Samuel, Huddersfield. ‡. NS.

1875 Knox, John, M.D., Resident Medical Officer to Bethnal House, E.

1868 Lake, W. C., M.D., Teignmouth, Devon. ‡ 2, ||. NS.

1875 Lattey, James, 23, St. Mary Abbotts-terrace, Kensington, W.

1858 Lawson, George, F.R.C.S., 12, Harley-street, W., Surgeon to the Royal London Ophthalmic Hospital, and Surgeon to the Middlesex Hospital. VP 2, C 3, ‡ 4.

1873 Lawson, Henry, M.D., 40, Weymouth-street, Portland-place, W., Assistant Physician to St. Mary's Hospital, and Lecturer on Physiology to St. Mary's Medical School (*Councillor*).

1853 Leared, Arthur, M.D., F.R.C.P., 12, Old Burlington-street, W., Senior Physician to the Great Northern Hospital. C 3, O, ‡ 5, || 2.

1875 Lee, E. Samuel, Fever Hospital, Stockwell, E.

1869 Lee, C. A., M.D., Surgeon, R.N. NS.

1852 Lee, Henry, F.R.C.S., 9, Savile-row, W., Surgeon to St. George's Hospital. VP 2, C 4, ‡ 6, LL.

1873 Lee, R. J., M.A., M.D., 6, Savile-row, W., Assistant Physician to the Hospital for Sick Children. ‡ 2.

1858 Lemon, Oliver, Langley-hill House, Kings Langley, Herts. ||.

1876 Lewis, Louis, M.D., 73, Albert-street, Regent's-park, N.W. ‡.

1867 Lichtenberg, George, M.D., 47, Finsbury-square, Surgeon to the German Hospital. || 4, ‡, C 2.

1874 Liebreich, Richard, 16, Albemarle-street, W., Ophthalmic Surgeon and Lecturer at St. Thomas's Hospital.

1869 Lipscomb, John T. N., M.D., F.R.C.S., St. Albans, Herts. NS.

1868 Littleton, Thomas, M.B., F.R.C.S., Plymouth, Physician to the Plymouth Public Dispensary. || 2. NS.

1870 Lloyd, Ridgway R. C. C., St. Albans. NS.

1873 Loe, J. S., 147, Woodhouse-lane, Leeds, Surgeon to the Leeds Fever Hospital. || 2, ‡.

1868 Lowe, John, M.D., King's Lynn, Medical Attendant to their Royal Highnesses the Prince and Princess of Wales at Sandringham; Consulting Surgeon to the West Norfolk and Lynn Hospital. NS.

1876 Lucas, T. P., Hercules-buildings, Westminster-bridge-road, S.

1868 Lund, Edward, F.R.C.S., Manchester, Surgeon to the Manchester Royal Infirmary; Professor of Surgery at Owens College. NS.

1869 Lunn, Wm. J., M.D., Hull, Senior Surgeon to the Hull General Dispensary. NS.

1871 MacCormac, William, M.A., F.R.C.S., 13, Harley-street, W., Surgeon and Joint Lecturer on Surgery at St. Thomas's Hospital. ||, ‡, C 3.

1862 Mackenzie, Morell, M.D., 19, Harley-street, W., Physician to the Hospital for Diseases of the Throat, and Lecturer on Diseases of the Throat at the London Hospital. ‡ 2, ||.

Elected

1868 MACKINDER, DRAPER, M.D., Gainsborough. NS.

1861 MACLAREN, A. C., 60, Harley-street, W. || 2, ‡ 4.

1865 MACPHERSON, J., M.A., M.D., 35, Curzon-street, Mayfair, W., Inspector-General of Hospitals, H.M. Bengal Army (Retired). || 4, ‡ 2.

1869 MAGILL, M., M.D., F.R.C.S., Staff-Surgeon, R.N. ‡ 2. NS.

1873 MANSFIELD, PIERCE, M.D., Staff-Surgeon, R.N., 14, Surrey-villas, Upper Norwood.

1876 MANVILLE, B. E., 5, Grosvenor-street, W.

1868 MARSH, JOHN C. LORY, M.D., Greenhithe, Kent. ‡. NS.

1873 MARSHALL, EDWARD, Church House, Mitcham, Surrey.

1869 MARSHALL, JAMES, M.D., Aberdeen. NS.

1869 MARSHALL, WILLIAM, M.D., Mortlake, Surrey.

1865 MARSHALL, W. G., F.R.C.S., Medical Superintendent Female Department, Asylum, Colney Hatch, Middlesex. || 3, ‡ 3.

1873 MARTIN, ADAM RAE, "The Precincts," Rochester, Surgeon to St. Bartholomew's Hospital, Chatham. ‡.

1871 MARTLAND, W., Blackburn. NS.

1862 MASON, FRANCIS, F.R.C.S., 5, Brook-street, Grosvenor-square, Surgeon to, and Lecturer on Anatomy at, St. Thomas's Hospital. VP, C 4, ‡ 7, SM, O, S 2, || 6. (*Lettsomian Lecturer.*)

1869 *MATHEWS, ROBERT, Bickley, Kent. || 2. NS.

1859 *MAUNDER, C. F., F.R.C.S., 16, Queen Anne-street, Surgeon and Demonstrator of Operative Surgery, London Hospital. || 2, LL, VP. (*Councillor.*)

1871 MAURICE, OLIVER C., Reading. NS.

1851 MAY, W. COSTALL, 52, Tregunter-road, South Kensington. ‡ 4, || 3.

1862 MAYBURY, A. K., M.D., Richmond, Surrey. NS.

1869 MCDONAGH, JAMES A., F.R.C.S., Mornington Villa, 211, Hampstead-road, N.W. ||.

1869 MCHARDY, MALCOLM M., 1, Eccleston-street, S.W.

1868 MCINTYRE, J., M.D., Odiham, Hants. NS.

1865 MCOSCAR, JOHN, M.D., 4, Argyll-street, Regent-street, W. ‡.

1866 MEREDYTH, COLOMIATI A. W. L., M.D., 10, George-street, Hanover-square, W. ‡.

1873 MÉRIC, HENRY DE, 52, Brook-street, W., Assistant Surgeon to the French Hospital. ‡ 2.

1873 MERRYWEATHER, HENRY, M.D., 17, Howard-street, Sheffield, Lecturer on Dental Surgery at the Sheffield School of Medicine.

1865 MIDDLEMIST, R. P., 10, Bedford-place, Russell-square, W.C. ‡ 3, || 3.

1858 MILLAR, JOHN, Medical Superintendent to the Bethnal House Asylum, E. ‡ 8, || 3.

1859 MILLER, WILLIAM, 15, Duke-street, St. James's, S.W. ‡ 4.

1860 *MONTEFIORE, N., F.R.C.S., 18, Portman-square, W. ‡ 4, || 4.

1875 MOORE, JOSEPH, M.D., Balham. ‡.

1871 MORLEY, ALEXANDER, 42, Albemarle-street, W. || 4, ‡ 4.

1868 MURRAY, JOHN CARRICK, M.D., Newcastle-on-Tyne. NS.

Elected

1868 Murray, J. Jardine, F.R.C.S. Edin., Brighton, Surgeon to the Sussex and Brighton Infirmary for Diseases of the Eye. ‡. NS.

1873 Myers, H. R., 30, Euston-square, N.W.

1868 Nankivell, Charles B., M.D., Torquay, Senior Physician to the Consumption Hospital, Torquay. NS.

1870 Napier, William Donald, 22, George-street, Hanover-square, W. ‖ 5, ‡ 4 (*Councillor*).

1877 Nesbitt, Dawson, M.D., 34, Cambridge-place, Hyde-park, W.

1868 Nevins, Birkbeck J., M.D., Liverpool, Lecturer on Materia Medica at the Royal Infirmary Medical School. ‡. NS.

1876 Newham, James, 16, Princes-street, Cavendish-square, W.

1871 Nicholls, John F., M.D., Devizes. NS.

1868 Noble, Daniel, M.A., M.D., F.R.C.P., Manchester. NS.

1869 Norris, William, M.D., Stourbridge. NS.

1871 Ogle, William, M.A., M.D., F.R.C.P., Derby, Physician to the Derbyshire General Infirmary. NS.

1873 Ogston, Alexander, M.D., 252, Union-street, Aberdeen, Surgeon to the Aberdeen Royal Infirmary. NS.

1872 Ogston, Francis, M.D., 156, Union-street, Aberdeen, Professor of Medical Logic and Jurisprudence to the University of Aberdeen. NS.

1875 Ord, William M., M.B., F.R.C.P., 7, Brook-street, W., Assistant Physician and Lecturer on Physiology at St. Thomas's Hospital.

1868 Osborn, John, M.D., F.R.C.S., Bitterne, near Southampton. NS.

1873 Owen, Francis, Sunnyside, Leatherhead. ‖.

1877 Paramore, Richard, 18, Hunter-street, W.C.

1867 Parkinson, George, 50, Brook-street, Grosvenor-square, W. ‖ 2, ‡.

1871 Parsons, F. H., M.D., Mount Pleasant, Hastings. NS.

1872 Patten, Charles A., Medical Officer of Health, Cambridge-villa, Ealing, W.

1854 Paul, J. H., M.D., Camberwell House, Camberwell, S.E. c 6, ‡ 7, ‖ 4.

1854 Pavy, F. W., M.D., F.R.C.P., F.R.S., 35, Grosvenor-street, W., Physician and Lecturer on Physiology at Guy's Hospital, &c. LL, C, VP, ‡.

1871 Pedler, George H., 6, Trevor-terrace, Knightsbridge, S.W. ‖.

1869 Pemberton, Oliver, F.R.C.S. Ed., Birmingham, Surgeon to the Birmingham General Hospital; Professor of Surgery at Queen's College. NS.

1870 Pennefather, John, Regent-street, W., Surgeon to the Metropolitan Dispensary for Diseases of the Ear. ‡ 3.

1868 Percival, Charles J., M.D., 7A, Manchester-square, W. ‖.

1873 Perez, Diego, M.D., Monte Video.

1871 Perrigo, James, M.D., Montreal. NS.

1873 Phillips, G. R. T., 17, Garway-road, Leinster-square, Hyde-park. ‖.

1876 Phillips, C. D. F., M.D., F.R.C.S. Ed., 107, Lancaster Gate, W. ‡ 2.

1869 Philipson, George H., M.A., M.D., F.R.C.P., Professor of Medicine, University of Durham, Newcastle-on-Tyne. NS.

Elected

1875 Philpot, Harvey J., Cressingham House, Peckham-rye, S.E.

1873 Port, H., M.D., 10, Finsbury-place, North, E.C., Assistant Physician to the German Hospital.

1850 Potts, William, F.R.C.S., 12, North-Audley-street, W. c 3, ‡, ||.

1868 Powell, Josiah T., M.D., 347, City-road, E.C.

1871 Powell, R. Douglas, M.D., F.R.C.P., 15, Henrietta-street, Cavendish-square, W., Physician to the College for Consumption and Diseases of the Chest, Brompton; Lecturer on Materia Medica at, and Senior Assistant Physician to, the Charing-cross Hospital. c 2, || 3, ‡ 4.

1869 Price, William Preston, M.D., Margate. ns.

1869 Prior, C. E., M.D., St. Peter's, Bedford, Coroner and Analyst for Bedford. ns.

1873 Purcell, F. Albert, M.D., 35, Welbeck-street, W., Assistant Surgeon Cancer Hospital, Brompton.

1870 Quain, Richard M.D., F.R.C.P., F.R.S., 67, Harley-street, W., Consulting Physician to the Hospital for Consumption and Diseases of the Chest, Brompton, &c. c 3, ||.

1869 Radford, Thomas, M.D., F.R.C.S. Ed., Manchester, Hon. Consulting Physician to St. Mary's Hospital, Manchester. ns.

1861 Ramskill, J. S., M.D. Lond., 5, St. Helen's-place, Bishopsgate-street, E.C., Senior Physician to the Hospital for Paralysis and Epilepsy; Physician to the London Hospital. ‡.

1859 *Rayner, John, 55, Highbury-quadrant. ‡ 2.

1851 Read, Reginald, F.R.C.P. Ed., 1, Guilford-place, W.C. c 2.

1850 Rees, G. Owen, M.D., F.R.C.P., F.R.S., 26, Albemarle-street, W., Consulting Physician to Guy's Hospital. vp 2, ll.

1872 Reynolds, J. Russell, M.D., F.R.C.P., F.R.S., 38, Grosvenor-street, W., Professor of the Principles and Practice of Medicine in University College; Physician to University College Hospital. ‡, c 3.

1872 Richards, J. P., Medical Superintendent, Female Department, County Asylum, Hanwell. ‡ 3.

1850 Richardson, Benjamin W., M.A., M.D., LL.D., F.R.S., F.R.C.P. (fm 1854), 12, Hinde-street, Manchester-square, W. p, vp, ll, c 5, o, ‡ 10, || 2.

1872 Ringer, Theobald, M.D., 7th Bengal Cavalry. ns.

1861 Risdon, R., 7, James-street, Buckingham-gate, S.W. ‡ 6, || 2.

1830 Robarts, H. P., F.R.C.S. (fm 1844), 30, Keppel-street, W.C. vp 2, c 10, s 9, sm, ‡ 7, ||.

1874 Roberts, Frederick Thomas, M.D., B. Sc., 53, Harley-street, W., Assistant Physician and Teacher of Clinical Medicine, University College Hospital; Assistant Physician to the Hospital for Consumption and Diseases of the Chest, Brompton. ‡ 2.

1863 Roberts, A. T., M.D., 32, Buckingham-road, Brighton.

Elected

1869 Roberts, Bransby, M.D., Badlesmere House, Eastbourne, Consulting Physician to the Eastbourne Provident Dispensary. ‡, ns.

1868 Roberts, David Lloyd, M.D., Manchester, Physician to St. Mary's Hospital, Manchester. ns.

1857 Roberts, D. W., M.D., 56, Manchester-street, W.

1859 Roberts, J. H., F.R.C.S., 82, Finchley-road, N.W. ‖ 3.

1873 Robertson, W. H., J.P., M.D. F.R.C.P., Buxton, Derbyshire.

1869 Roden, William, M.D., Kidderminster. ns.

1868 Rogers, Adams M., Surgeon H.M. Bombay Army. ns.

1869 Rogers, C. E. H., Retford, Notts. ns.

1856 Rogers, J., M.D., 33, Dean-street, Soho, W., Visiting Medical Officer to the Westminster Union Infirmary.

1847 Rogers, Wm. Rd., M.D., 56, Berners-street, W., Physician to the Samaritan Free Hospital for Women and Children, and Consulting Surgeon to the Hospital for Women and Children, Vincent-square. vp, c 6, ‡ 5.

1868 Rolleston, George, M.D., F.R.S., F.R.C.P., Oxford, Linnean Professor of Anatomy ; Honorary Physician to the Radcliffe Infirmary. ns.

1869 Roome, Henry, M.D., Parkhurst, Isle of Wight. ns.

1874 Rose, William, F.R.C.S., 20, Welbeck-street, Assistant Surgeon to King's College Hospital.

1876 Ross, A. C., Rossland House, Denmark-terrace, Brighton.

1876 Routh, A. C., 159, Camberwell-road, S.E.

1848 Routh, C. H. F., M.D., 52, Montagu-square, W., Physician to the Samaritan Free Hospital, &c. p, vp 2, s. 4, c 6, ‡ 9, sm, ‖ 5 (*Trustee*).

1870 Sams, John Sutton, Eltham-road, Lee, S.E.

1869 Sandwell, Edward, 10, Charles-street, Soho-square, W. ‖ 4.

1863 Sansom, A. E., M.D., 30, Devonshire-street, Portland-place, W., Assistant Physician to the London Hospital, and Physician to the North-Eastern Hospital for Children. p, c 4, sm, s 2, ‡ 8, ‖ 3, §.

1873 Satchell, W. A., F.R.C.P. Edin., Groombridge, Tunbridge Wells. ‖ 2.

1873 Scott, William, M.D., Waverley House, Huddersfield, Senior Physician to the Huddersfield Infirmary. ‡.

1873 Sedgwick, James, M.D., Boroughbridge, Yorkshire.

1868 Sedgwick, Leonard W., M.D., 2, Gloucester-terrace, Hyde-park, W. c 4, § 3, ‡ 6, ‖ 2 (*Vice-President*).

1869 Semple, Robert H., M.D., F.R.C.P., 8, Torrington-square, W.C., Physician to the Hospital for Diseases of the Throat; Physician to the Eastern and Bloomsbury Dispensaries. ‡ 3, ‖ 2 (*Councillor*).

1876 Sewell, Charles Brodie, M.D., 21, Cavendish-square, W. ‡.

1865 Sewill, H. E., 6, Wimpole-street, Dental Surgeon to the West London Hospital. ‡ 3, ‖.

1874 Sheppard, Edgar, M.D., F.R.C.S., Professor of Psychological Medicine, King's College, London, and Resident Superintendent (Male Department), County Asylum, Colney Hatch, N. ‡.

Elected

1871 SHETTLE, R. C., M.D., Reading, Physician to the Royal Berkshire Hospital. ||. NS.

1871 SHIPTON, W. PARKER, Buxton, Derbyshire, Consulting Surgeon to the Devonshire Hospital.

1868 *SIMMS, FREDERICK, M.B., 13, Albert-mansions, Victoria-street, S.W. ‡, C 2, || 3.

1868 SIMS, T. MARION, M.D., Paris. NS.

1873 SKINNER, STEPHEN, M.B., Clevedon, Somerset, Surgeon to the Clevedon Dispensary.

1873 SLATER, JOHN T., M.D., 1, Thornhill-crescent, Islington, N.

1862 SLIGHT, GEORGE, M.D., 25, Brewer-street, W. ‡ 2, C 2.

1871 SLOMAN, S. G., Farnham. NS.

1845 SMILES, WILLIAM, M.D., 44, Bedford-square, W.C., Surgeon to the House of Correction, Coldbath Fields, and House of Detention, Clerkenwell. VP 2, S 4, C 9, SM, ‡ 6.

1871 SMITH, EUSTACE, M.D., F.R.C.P., 5, George-street, Hanover-square, W., Physician to H.M. the King of the Belgians; Physician to the East London Children's Hospital; and Assistant Physician to Victoria-park Hospital for Diseases of the Chest. ‡.

1873 SMITH, GILBART, M.A., M.D., 68, Harley-street, W., Physician to the Royal Hospital for Diseases of the Chest. ||, ‡ 3.

1848 *SMITH, HENRY, F.R.C.S., 82, Wimpole-street, Professor of Surgery at King's College Hospital, and Consulting Surgeon to the Westminster General Dispensary. P, VP, C 3, O, LL, ‡ 10, || 4.

1873 SMITH, HEYWOOD, M.A., M.D., 2, Portugal-street, Grosvenor-square, W., Physician to the Hospital for Women, and British Lying-in Hospital. || 2, ‡ 2.

SMITH, J. GREGORY, Honorary Fellow, *q. v.*

1877 SMITH, SIDNEY L., 112, Gower-street, W.C.

1872 SMITH, WALTER, Esq., 2, Stanhope-terrace, Gloucester-gate, Regent's-park, N W.

1874 SMITH, W. ROBERT, M.B., 258, St. Philip's-road, Sheffield.

1874 SMYTH, WILLIAM WOODS, Kent County Ophthalmic Hospital, Maidstone.

1869 SPENDER, JOHN KENT, M.D., Bath. FM. 1874. NS.

1864 SQUIRE, A. J. BALMANNO, M.B., F.L.S., 24, Weymouth-street, Portland-place, Surgeon to the British Hospital for Diseases of the Skin, Great Marlborough-street.

1869 STEAR, HENRY, Saffron Walden, Surgeon to the Saffron Walden Hospital. NS.

1869 STEDMAN, JAMES R., M.D., Guildford, Consulting Surgeon to the Surrey County Hospital. ‡ 3. NS.

1848 STOCKER, JOHN SHERWOOD, M.D., 2, Montagu-square, W., Physician to the Western General Dispensary. C 10, S 2, ‡ 7, ||.

1873 STRANGE, W. HEATH, M.D., 2, Belsize-avenue, Belsize-park, Surgeon to St. Martin's Dispensary for Fistula.

Elected

1876 Sutherland, Henry, 6, Richmond-terrace, Whitehall, S.W., Lecturer on Insanity at the Westminster Hospital.

1874 Sutro, Sigismund, M.D., F.R.C.P., 37A, Finsbury-square, E.C., Senior Physician to the German Hospital.

1864 Tait, E. W., F.R.C.S., 10, Highbury-park, N. ||, ‡.

1870 Tait, Lawson, F.R.C.S., 7, Great Charles-street, Birmingham, Surgeon to the Birmingham and Midland Hospital for Women. ns.

1875 Tamplin, C. H., 52, Maddox-street, W.

1869 Taylor, Charles Bell, M.D., F.R.C.S., Nottingham, Honorary Surgeon to the Nottingham and Midland Eye Infirmary.

1863 Teevan, W. F., B.A., F.R.C.S., 10, Portman-square, W., Surgeon to the West London Hospital and to St. Peter's Hospital. c 3, o, ‡ 5, || 5.

1858 Thane, G. D., M.D., 15, Montague-street, Russell-square. † 2, ‡.

1874 Thomas, Llewellyn Morgan, M.D., 15, Weymouth-street, Portland-place, W., Physician to the Royal Academy of Music. ‡.

1876 Thomason, W. J., M.D., R.N., 28, Lyme-street, N.W.

1859 Thompson, E. Symes, M.D., F.R.C.P., 3, Upper George-street, Bryanston-square, W.; Physician to the Hospital for Consumption and Diseases of the Chest, Brompton, S.W.; Gresham Professor of Medicine, &c. vp, s 3, sm, c 3, ‡ 9, || 5.

1855 Thompson, Sir Henry, F.R.C.S., 35, Wimpole-street, W., Surgeon Ext. H.M. King of the Belgians and Commander Order Leopold; Professor of Clinical Surgery to University College Hospital, &c. vp, c 4, ll, ‡ 9, ||.

1873 Thomson, John R., M.D., Dunedin, Bournemouth, Consulting Physician to the Bournemouth General Dispensary.

1871 Thorne, Wm. Bezly, 46, Harcourt-terrace, Redcliffe-square, South Kensington, S.W.

1876 Thornton, J. Knowsley, M.B., M.C., 83, Park-street, W., Surgeon to the Samaritan Free Hospital for Women and Children. ‡.

1870 Thornton, W. Pugin, 42, Devonshire-street, Portland-place, W., Surgeon to the St. Marylebone Dispensary. ||.

1867 Thorowgood, John C., M.D., F.R.C.P., 61, Welbeck-street, W., Physician to the City of London Hospital for Chest Diseases, and Lecturer on Materia Medica at the Middlesex Hospital. l, s 2, sm, c 2, ‡ 6, || 3 (*Vice-President, Chairman of Council*).

1854 Thudichum, J. L. W., M.D., 11, Pembroke-gardens, Kensington, W. vp, c, o, ll, ‡ 11, || 2.

1876 Tibbits, Herbert. M.D., F.R.C.P. Edin., 26, Cavendish-square, W., Medical Superintendent of the National Hospital for the Paralysed and Epileptic.

1873 Tidy, Charles Meymott, M.B., 48, Queen Anne-street, W., Professor of Chemistry and Medical Jurisprudence, London Hospital; Medical Officer of Health for Islington.

Elected

1848 Tilt, E. J., M.D., 27, Seymour-street, Portman-square, W., Consulting Physician to the Farringdon General Dispensary and Lying-in Charity. c 4, ‡ 2, ‖ 4.

1867 Timms, Godwin W., M.D., 9, Wimpole-street, W., Senior Physician to the North London Hospital for Consumption.

1836 Townley, James, F.R.C.S., F.L.S., 302, Kennington-park-road. c 3, ‡ 11, ‖ 5.

1863 Travers, William, F.R.C.S., 2, Phillimore-gardens, Kensington. ‖, ‡.

1868 Tuke, Thomas Harrington, M.D., F.R.C.P., 37, Albemarle-street, W. c 2, ‡ 2.

1871 Vanderstraaten, J. L., M.D., Ceylon. ns.

1874 Verley, R. Louis, 88, Gower-street, W.C. ‡.

1850 Waggett, John, M.D., F.R.C.S., 40, Ladbroke-grove, Kensington-park-gardens, W. ‡ 2, ‖.

1850 Wakley, Thomas H., F.R.C.S., 96, Redcliffe-gardens, South Kensington, S.W., Consulting Surgeon to the Royal Free Hospital. ‡ 4.

1877 Walker, George, 1, St. George's-place, S.W.

1869 Walker, John Swift, M.D., Hanley. ns.

1869 Walker, Joseph, M.D., L.D.S., 22, Grosvenor-street, W., Dental Surgeon and Lecturer, Westminster Hospital.

1868 Wane, Daniel, M.D., 20, Grafton-street, Bond-street, W.

1867 Walton, Haynes, F.R.C.S., 1, Brook-street, Hanover-square, W., Surgeon to St. Mary's Hospital. ll.

1872 Waters, John, 41, Bloomsbury-square, W.C. ‡, ‖ 2.

1868 Watkins, Charles S., 16, King William-street, Strand, W.C. ‡ 2, ‖.

1863 Watson, W. Spencer, F.R.C.S., 7, Henrietta-street, Cavendish-square, W., Surgeon to the Royal South London Ophthalmic Hospital, and to the Great Northern Hospital. c, ‡ 3, ‖ 3.

1869 Webster, F. R., St. Albans, Herts. ns.

1838 Wells, J. R., F.R.C.S., 20, Fitzroy-street, W. c 2, ‡ 6, ‖ 4.

1873 Welsh, Joseph, Knighton, Radnorshire.

1875 White, J. C., Ardwick and Ancoats Dispensary, Manchester.

1869 White, Joseph, F.R.C.S. Edin., Nottingham, Surgeon to the Nottingham General Hospital. ns.

1877 Whitmore, W. Tickle, 7, Arlington-street, Piccadilly, W.

1872 Whitton, George E., M.B., Madras Army. ‖. ns.

1868 Wiblin, John, F.R.C.S., Southampton. ns.

1871 Wilkinson, J. Sebastian, F.R.C.S., 83, Wimpole-street, W., Surgeon to the Central London Ophthalmic Hospital, and to St. George's, Hanover-square, Dispensary.

1862 Willett, E. Sparshall, M.D., Wyke House, Syon-hill, Isleworth. c 3, ‡ 5, ‖ 4.

1872 *Williams, A. Wynn, M.D., 1, Montagu-square, W., Physician to the Samaritan Hospital. ‡, ‖.

Elected

1872 Williams, C. Theodore, M.A., M.D., F.R.C.P., 47, Upper Brook-street, Grosvenor-square, W., Physician to the Hospital for Consumption and Diseases of the Chest, Brompton. s 2, sm, ll, ‡ 5, || 3 (*Librarian*).

1868 Williams, Henry L., M.D., 9, Leonard-place, Kensington. ||.

1876 Williams, H. W., M.D., 168, Fulham-road, S.W. ‡.

1873 Wills, T. M., F.R.C.S.I., 59, Clifford-villas, Merton-road, Bootle, Liverpool, Surgeon to the Bootle Hospital.

1870 Wilson, Erasmus, F.R.S., F.R.C.S., 17, Henrietta-street, Cavendish-square, Professor of Dermatology to the Royal College of Surgeons. o, || 5, ‡ 4, c 2 (*Councillor*).

1870 Wiltshire, Alfred, M.D., 57, Wimpole-street, Physician for Diseases of Women to the West London Hospital; Assistant Physician-Accoucheur to St. Mary's Hospital. c 3, ‡ 4, ||, s 2, sm, ll (*Chairman of Council*).

1873 Winslow, L. S. Forbes, M.B., D.C.L., 23, Cavendish-square, W., Lecturer on Mental Diseases at the Charing-cross Hospital. ‡ 3.

1870 Wise, James, M.D., Dacca, Bengal. ns.

1872 Wise, W. C., M.D., 241, Burrage-road, Plumstead, Physician to the Plumstead Dispensary.

1876 Woakes, Edward, M.D., 57, Harley-street, W. ‡.

1861 Wolff, Abraham, F.R.C.S., 48, Gloucester-gardens, Hyde-park, W. ||, ‡ 3.

1873 Woodhouse, R. Hall, 1, Hanover-square, W.

1869 Wookey, James, Potters Bar, Barnet. ns.

1873 Wordsworth, J. Cawood, F.R.C.S., 20, Harley-street, W., Surgeon to the Royal London Ophthalmic Hospital. (*Councillor.*)

1870 Ziffo, Jean E., Constantinople. ns.

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PROCEEDINGS

OF THE

MEDICAL SOCIETY OF LONDON.

Monday, October 18th, 1875.

Dr. Routh, President, in the Chair.

Mr. Henry Smith brought forward a case of

SIR WM. FERGUSSON'S OPERATION ON THE HARD AND SOFT PALATE.

The cleft extended to all the soft and most of the hard palate. The patient was in poor health, and the result was quite successful. The instruments used were shown.

In answer to Mr. Oakley Coles Mr. Henry Smith said that, though the soft palate was well developed, the edges over the hard palate were very thin.

Dr. Hutchinson showed a small ovarian cyst semi-solid, and containing a glairy fluid, removed by Mr. Spencer Wells.

A paper was read by Dr. Routh on

HYPERPYREXIA VIEWED ESPECIALLY IN ITS SURGICAL ASPECTS.

After some preliminary remarks, five cases were given.

Case 1.—A case of *ovariotomy*, where the patient went on well for two days, all the symptoms being favorable. On the third day the temperature was at 102° in axilla in the morning. At 1 p.m. it ran up to 103°, and then rapidly to 109·2° by 6 p.m., when she died. It rose to 110° after death. The post mortem revealed very limited peritonitis.

Case 2 was much longer and more tedious. One of *menorrhagia*, from which a large, and three smaller intra-uterine *polypi* were removed. Subsequently the temperature rose to 105° in vagina, and rapidly, on three successive occasions. Three sea-water baths were given, with great benefit each time, but to the last the temperature in vagina kept up, off and on, to 104°. She died of exhaustion in twelve days. Post mortem revealed extensive peritonitis and *clot* in the heart.

Case 3.—A case of *fibroid of uterus*, to which the galvanic cautery was applied. Here, also, the temperature rose on three successive times to 105° rapidly, and three ice-baths were given in two days. Complete recovery followed.

Case 4.—A more tedious case of *menorrhagia*. Hyperpyrexia, temperature rising rapidly to 106°, with head symptoms, &c. In this case three baths brought down the temperature on three different days, but still, although brought down to 99° on every occasion, it rose again, generally once in the twenty-four hours, reaching 103°, and then going down again. An abscess eventually formed between the rectum and vagina, and she did well.

Case 5.—A case of *fibroid of the uterus*, in which gastrotomy was performed. The patient went on well till the eighth day, when the temperature suddenly rose to 107°, with delirium, and at last unconsciousness. This case rapidly recovered in the ice-bath. At a later period a second ice bath was called for, the temperature again suddenly rising to 105°. From this time she gradually got better. In this case also a cæco-rectal abscess formed. Cure followed its being opened.

Dr. Routh made the following deductions from these and similar cases:

1st. The effect of cold was most marked, and immediate, in some of these cases, Case 5 being almost immediately cured by a bath, which if administered in Case 1 might also have saved life.

2nd. The effect of cold in Case 4 was not so marked. In Case 2,

although it ameliorated the symptoms, it did not prevent death by peritonitis and exhaustion.

3rd. The causes of the hyperpyrexia in two of the cases was clearly made out, each being poisoned by a bad case of low peritonitis imported into the ward, which also poisoned several other cases.

The good effect of cold was best seen in those cases where it was *early* and *effectively* employed. Delay in adopting it naturally influenced its fortunate results.

5th. A blue colour, and sickness, occasionally were observed after a patient had been in the cold bath for some time, (three quarters of an hour), but removal from it at once, or very soon, led to their entire disappearance.

6th. Ice-bags to the spine often appeared inoperative for good; nay, temperature appeared to rise. Ice on jugulars, chest, and head, were more effective for good. Dr. Routh believed the ice-bag to the spine, as shown by Dr. Chapman, had, by producing paralysis of vaso-motor nerves, a tendency to warm the extremities, and to lead to injuries of spine. Perhaps it was the influence of the two combined that brought up temperature to 122° in Mr. Teale's case.

7th. He believed this increase of temperature was a purely chemical change, as it continued after death, but it did not appear to have any relation to the respiration.

8th. His cases did not perspire till long after convalescence had been restored. Even Jaborandi never induced perspiration, and in a few cases perspiration ushered in death.

9th. All pain was relieved, and generally entirely removed, by the bath.

10th. No sort of connection whatever was observed between the temperature, respiration, and circulation. Only cases with low pulse seemed to do better.

11th. Temperature in vagina, as a rule, was always one degree higher than in axilla. Occasionally, however, it was three, and even four degrees higher. Even in ordinary menstruation it may rise to 103° in the vagina, while only 99° in axilla. Sometimes, however, it was the same in both places. In the mouth it was generally three tenths above the axilla.

Mr. Maunder considered that the cold steel might have been as advantageous as the cold bath in the two cases where pus had been retained.

Dr. Thudichum, as a chemist, criticised the value of the ice-bath in influencing a pyrexia; more should first be known as to how a pyrexia is established.

Dr. Rogers eulogised the ice-bath, and generally concurred with the President's views.

Dr. Day considered the ice-cap more convenient. Neither quinine, aconite, nor calomel, possessed the value of the ice-cap in reducing temperature.

Dr. Broadbent preferred the wet-sheet packing. He had found that the longer the temperature is allowed to remain in a condition of hyperpyrexia, the more difficult it is to get it down. He approved of cold baths and the ice-cap in axillary and vaginal thermometric discrepancies; great care must be taken to register accurately.

Dr. Williams preferred to take readings by the mouth, rectum, or vagina. The cold bath had a decided effect on the urine, rendering it watery, and dilute. At times the temperature kept falling, until it became too low; stimulants were then necessary; warm milk readily brought up the temperature (Hermann Weber).

Mr. Jabez Hogg inquired whether the same thermometer was used, and whether it was compared with our standard.

Dr. Evans inquired if sleep resulted from the use of the cold bath.

Dr. Routh having replied, the meeting adjourned, the two last queries having been affirmatively answered.

Monday, October 25th, 1875.

Dr. Routh, President, in the Chair.

Dr. Thorowgood narrated a case of a man, aged 45, admitted into the West London Hospital 24th May, 1875. He had all the signs of pneumonia at the right base. On the seventh day the expectoration, from being rusty, became black and offensive; his condition was critical between the tenth and fourteenth days. Temperature 102·6°; breath intensely fœtid. This man had bark and ammonia, 6 oz. of brandy, and 4 oz. wine, per diem. On the 7th

September he resumed work, having still some cough and expectoration, and dulness at base of right lung. Dr. Thorowgood stated that gangrene was rare as a termination of acute pneumonia; a limited slough of lung tissue, probably caused by plugging of the vessels by pneumonic exudation, here existed; this sufficed to cause the great fœtor. The patient improved under liberal stimulation. The man previously was subject to winter cough, otherwise of good health, sound mind; no albuminuria; no history of intemperance.

Dr. Williams suggested that some great trial, as long bathing, induced these attacks. The sputa has a peculiar cowslip-odour by keeping. Did disinfectant inhalation relieve the cough? This disease is infrequent here, but from Laennec's tables seemed to be common in France.

Dr. Rogers thought brandy, gallic acid, muriate of iron, port wine, beef tea, milk, and eggs, were the correctives for this disease.

Dr. Farquharson considered it difficult to distinguish between a vomica and dilated bronchus. He believed that some reported cases of gangrene of the lung were simply bronchorrhœa.

Surgeon Myers inquired if phthisis was present, and considered that the two diseases were at times associated.

The President thought that this disease occurred under four circumstances:—(1) A vomica contained decomposing lung; (2) limited pneumonia, with much fœtor; (3) bronchorrhœa dependent on dilated bronchi; (4) in persons exposed to typhus or bad exhalations the lungs excreted a discharge, opening sometimes from the liver.

Dr. Thorowgood replied. Lunatics often died of extensive gangrene of the lung; plugging of the pulmonary vessels might also lead to gangrene.

Mr. S. J. Hutchinson narrated a rare form of hæmorrhage that was dependent on an ulcer at the root of a canine tooth, induced by wearing false teeth. The man was dyspeptic.

In answer to Dr. Drysdale Mr. S. J. Hutchinson said he was not of the hæmorrhagic diathesis.

Mr. R. Davy exhibited a living specimen of hypertrophy of the buttock tissues. It had existed thirteen years. Measurement around waist $32\frac{1}{2}$ inches; around buttock 54 inches. The patient, a man, aged 38, was in good health. He was advised to wear a frock-coat

and a supporting-belt. However elegant a dress-improver might be to the female, it was simply inconvenient to the male. The tumour was fibro-fatty.

Mr. Maunder thought this tumour was not fatty, and drew the attention of the Society to Mr. Pollock's case of molluscum fibrosum operated on, and the man died.

Dr. Brunton stated that a Scotch giant, 6 feet $4\frac{1}{2}$ inches high, had presented very similar appearances.

Dr. Dowse exhibited a pathological specimen of aneurism of the aorta that had burst into the posterior wall of the trachea.

In reply to Dr. Symes Thompson, and Dr. Williams, Dr. Dowse stated that there was no dysphagia or dysphonia, but that the involved trunk of the pneumogastric had led to the dyspnœa.

Mr. Maunder said that it was probably in the recollection of some of the Fellows that about five years ago he had exhibited several patients, who had been submitted to excision of the elbow-joint, and who possessed an unusually good substitute for that elbow. Mr. Maunder explained his method of operation, by which active extension of the triceps muscle could be secured, and a most useful limb would be the result. He had just received (October 16th) a letter from one of his former patients, now resident in New Zealand, and who had been operated on six years ago, who says, "You will be glad to learn that my arm has won the champion billiard cue in the late match here, also that I took second honours in quoits . . . . . I have left a clause in my small will that my arm shall be preserved and sent to you for examination and dissection after my death. I believe it to be the finest arm in the world without a joint."

Mr. Henry Smith showed a strumous testicle that he had removed from a man, aged 45. Instead of applying a ligature to the cord he had used his clamp and cautery at nearly a red heat.

Mr. Royes Bell substantiated Mr. Smith's remarks, and said that he had tapped a cyst on this self-same scrotum. The patient had done well.

Dr. Drysdale inquired as to the condition of the epididymis. The diagnosis between strumous and syphilitic testis was obscure.

Surgeon Myers thought this plan good for hospitals, but preferred ligature in private practice.

Mr. Davy mentioned that he had tied the spermatic artery only in his last case of castration. In dogs he wrenched out the testis. Mr. Smith's plan was followed by farriers in castrating stallions.

Dr. Cook mentioned that the late Mr. Partridge removed a testis by evulsion.

Dr. Farquharson stated that the castration of lambs was performed by a man biting off the spermatic cords.

Mr. Henry Smith replied, and stated that, as a conservative measure, he had passed a thread through the spermatic cord.

Monday, November 1st, 1875.

Dr. Routh, President, in the Chair.

Mr. William Adams brought forward a patient on whom he had operated for depressed cicatrices. They had originally arisen from difficulty of dentition; there was exfoliation of bone, and the cicatrix was large enough to admit the finger. He used a tenotomy knife to remove the adhesions, and elevated the cicatrix by means of harelip pins for four days. The pins were taken out when the structures were succulent and infiltrated, and the result was successful.

Mr. Watson complimented Mr. Adams on his treatment, and stated that he had himself operated successfully on cicatrix over malar bone.

Mr. Royes Bell related a case of depressed cicatrix over orbital ridge; *then* the present operation failed, but Riverdin's transplantation of skin succeeded.

Mr. Adams replied.

Mr. Hainworth showed a portion of preserved veal. It had been kept in a solution, of specific gravity 1020, containing nitre, salt, borax, and boracic acid. He considered the plan useful for meat preservation and for dissecting-room purposes.

Mr. Davy stated that a solution very similar to this was now used at St. George's and the Westminster Hospitals for dissecting-room parts. The result, so far, had been satisfactory.

Monday, November 8th, 1875.

Dr. Routh, President, in the Chair.

Mr. W. Spencer Watson exhibited a case of

COMPOUND DISLOCATION OF THE ANKLE-JOINT

with comminuted fracture of the os calcis. Removal of the dislocated astragalus and a portion of the os calcis.

The patient (exhibited to the Fellows), from whom the astragalus was removed, was a girl, sixteen years of age, who had been injured in an explosion of gas at Southgate. The house, in which she was at the time working a sewing machine, was blown down, and the girl was found lying with her right foot under some part of a sewing machine. When brought into the Great Northern Hospital the head of the astragalus was seen to be thrust through the boot at the inside of the foot, the latter being dislocated outwards. After carefully cutting off the boot, and stocking, chloroform was administered by the house-surgeon, and, on exploring the wound with the finger, portions of the os calcis were found to be fractured, and one loose piece was removed. An attempt was then made to reduce the astragalus by forcible extension of the foot, pressure backwards being at the same time made upon the head of the protruded bone. It was, however, so firmly wedged in between the parts that all attempts at reduction failed. Mr. Watson then determined to remove it. The wound in the integuments was a clean lunated cut extending from the inner malleolus to about the centre of the front of the instep, and was as sharply incised as if it had been done with a scalpel. Seizing the head of the bone with the large lion-forceps, and drawing it well upwards and outwards, he first divided the internal, and then the external lateral ligaments of the ankle-joint. A few slight touches with the knife at the back of the joint, keeping the edge close to the bone, sufficed to liberate it, the interosseous ligament having, as it seemed, been torn through by the force of the injury. The tendon of the tibialis posticus was lying loose across the lower parts

of the wound. This was subsequently cut away by Mr. Jackson, who saw the patient later in the evening. Antiseptic carbolic-oil dressing was applied, and subsequently irrigation with carbolic-acid lotion, the limb being supported on a posterior splint. The patient made an excellent recovery, and a high boot, with an iron support to the ankle, enabled the girl to walk without difficulty. For many months after, there was occasional difficulty of progression, in consequence of some chronic synovitis of the knee, but this was ultimately overcome. The affected limb was three quarters of an inch shorter than the sound one. There was very good flexion and extension movement of the ankle-joint, and the deformity was so slight that the fact of the astragalus having been removed would hardly have been suspected. The muscles of the calf, however, became much wasted, and thus the appearance of the limb offered a considerable contrast to its fellow.

The ease with which the bone was removed serves to indicate the position in which the incision for its removal might be made in any case of injury or disease, though it must not be overlooked that, in this instance, the separation of the lower attachments of the os calcis and the dislocation of the head of the bone offered exceptional facilities, such as might not be met with in any subsequent case. No doubt the youth and vigour of the patient contributed in no slight degree to the favorable issue, and it must always be considered desirable, if possible, to reduce the dislocation before proceeding to remove the bone.

Mr. Jabez Hogg then read a paper on

SPINAL CONCUSSION.

The author drew attention to the disregard of life manifest in some of the recent railway injuries, which has awakened the community to a sense of horror, as many of them have arisen from preventable means. The most terrible and destructive form of railway accident is that by collision, and this in almost every instance upon investigation has been found to be due to causes within the control of those who have the management of the line. Under present circumstances there are no grounds for charging juries with the awardment of excessive damages, and sympathising with the injured.

In France, while better supervision is displayed, much larger damages are given in all cases than in this country; and it seems

only just that this should be acted on, as no money can compensate a family for the loss of the bread-winner. Then, as to the complaint of gross imposition practised, it is but natural to suppose that among the thousands annually injured there will be a few who may overstate the nature of their injuries, and try to make the best terms they can with the railway company, who systematically ignore the claims of their own mutilated servants, and whose widows and orphans are thrown upon the world without compensation or feeling of compassion. Mr. Hogg attributed the failure of justice in railway cases to the present mode of taking evidence and pitting professional men against each other, thus converting them into partisans. This, he contended, would be avoided by submitting these cases to the arbitration of properly instituted medical juries.

The symptoms of spinal concussion in all cases are either immediate or remote; in the majority the mischief does not supervene for days, weeks, or months, and in such they are not always well marked, and therefore, they are but casually noticed, or perhaps altogether passed over at the time. Dr. Abercrombie's opinion was that every injury to the spine should be considered worthy of minute attention, and demands the employment of active means for preventing and removing inflammatory action.

Impairment of vision is no uncommon symptom, and an examination of the visual field is of the utmost importance, and the appearances of the internal eye will often prove diagnostic to the detection of the earliest signs of inflammatory changes in concussion of the spine, as well as in intra-cranial mischief generally.

Of the pathological changes induced little is as yet known. The rareness with which autopsies can be got in such cases is the cause of this. Dr. Lockhart Clarke has had the opportunity of examining microscopically, injury to the cord in one case, and only in a very few cases have post mortems been made, after death by railway concussion, or shock. It has been ascertained, however, that the symptoms which follow injuries of the head are not always due to morbid changes in the cord. In Dr. Clarke's case the morbid changes closely resembled those observed in locomotor ataxy. In concussion, with impaired vision, injury to the fifth nerve is most common, and blows received about the neck or shoulders are more immediately followed by a disturbance of vision, and the more serious symptom of a creeping up of the meningitis to the brain. Evidence is wanting that inflammatory changes and loss of sight are

due to injury to the sympathetic nerve, as several cases are on record in which no neuro-retinitis, increased current of blood, augmented heat, increased secretions, and acute insensibility, has followed section of the sympathetic. On the other hand, there is much in connection with concussion of the spine to show that hyperæmia of the retina is dependent upon a greater or less extension of meningeal mischief to the base of the brain, and, in general, the higher the injury to the spine the sooner the affection to the eye. The ophthalmoscopic appearances of the internal eye vary greatly; limited to the central portion of the field, they gradually extend to the retina and other tissues, or capillary hæmorrhage obscures the periphery of the disc, and hyperæmia of the retina, producing serious impairment or loss of vision. Among the general symptoms numbness of the extremities, loss of motor power, derangement of the genito-urinary organs, and a sudden fall of temperature. To guard against the malingerer Mr. Hogg recommends the employment of the stereoscope for the detection of monocular blindness, and as a diagnostic aid in ascertaining the difference and acuteness of vision between the two eyes the Lucegrade or portable photometer, invented by Wheatstone and improved by Browning; this instrument consists of a prism of neutral-tinted glass, six inches in length, and corrected for refraction by means of a prism of crown glass, of the same length and angle, cemented to it. The tint of the prism is so graduated that a piece of white paper, receiving, and reflecting the light of the sky, can just be seen through the thinnest end, while the thickest admits of sunlight being clearly defined. By a rack-and-pinion movement this graduated prism is made to move before the eye, and opposite to the eye-piece is a tube with two cross wires. The prism should be moved until the image of the wires is just extinguished, when the index should be read off and noted.

The pathology of the nerve lesion after spinal injury is comprised in the brief report of a single case recorded in 'Path. Trans.,' vol. xvii, by Dr. L. Clarke. The patient, after an apparently slight accident received in a railway collision, died in about three years, and considerable degeneration of the cord was observed.

Particulars of eleven cases were then given. The treatment recommended was thorough rest, good nursing, and nourishment, and iodide of potassium, and bromide of ammonium, given in in-

creasing doses. In hysterical spine cases, change and the douche bath.

Mr. Wm. Adams thought that in these railway accidents the brain as well as the spinal cord suffered. He recommended counter-irritation, and especially the use of the seton.

Dr. Fothergill considered that the result of Mr. Hogg's treatment by mercury and iodide of potassium justified the suspicion of syphilis.

Dr. Dowse inquired whether the brain was examined in these cases. No choked disc could exist without central lesion of the brain or implication of the sinuses.

Mr. Sebastian Wilkinson related two interesting cases of direct shock. He was scarcely ready to associate spinal concussion with dimness of vision, but laid stress on a direct injury to the head.

Dr. Althaus drew attention to the cilio-spinal region—a tract of nervous matter influencing dilatation or contraction of the pupil. It was situated between the third cervical and first dorsal vertebræ. In progressive locomotor ataxy the disease travelled upwards; affections of vision occurred, ending in amaurosis.

Mr. Wordsworth considered that all these railway injuries recovered after compensation, and he had never discovered structural lesions in such by the aid of the ophthalmoscope.

Dr. Routh suggested the use of the nitrate of amyl; in these cases he had employed it with benefit. He asked what doses of iodide of potassium Mr. Hogg had given.

Mr. Hogg, in reply, stated from five to thirty grains of iodide of potassium, gradually increased. Many post-office clerks were annually discharged by reason of defective sight due to spinal concussion. He approved generally of counter-irritation.

Monday, November 15*th*, 1875.

Dr. Routh, President, in the Chair.

The discussion of Mr. Watson's case of excision of the astragalus was then opened by himself, who gave a short *résumé* of the leading points, and

Mr. Carr Jackson commended Mr. Watson for the operation. He had seen three of the kind, and the first of these was performed for disease of the astragalus, which had been mistaken for a compound fracture of the fibula. Amputation had been proposed, but Mr. Jackson recommended excision, and it had succeeded admirably. In the second case the removal of the astragalus necessitated the division of several tendons, but these reunited without bad result. The third case was the present one, and although it was very successful, Mr. Jackson remarked that the patient required an instrument, and it was a question as to whether amputation on the Pirigoff or the Symes' principle, as recommended by Sir J. Paget, would not be equally successful.

Mr. H. Royes Bell gave an account of an excision of the astragalus, occurring in Mr. John Wood's practice, and although it was followed by some abscesses about the joint, the case recovered with a fair amount of mobility of the joint.

Mr. W. Adams had carefully examined the patient at the last meeting, and bore witness to the success of the operation. He had no doubt as to its efficacy and to its coming into greater favour with the profession. He alluded to the proposition of Mr. Lund, to excise the astragalus in club-foot, which had been carried out with a fair amount of success.

Mr. Watson briefly replied.

Mr. H. Smith exhibited a foreign body, which had been impacted in the thigh of a youth who had fallen against a sharp piece of iron; a large induration formed on the thigh, and the wound did not close. The boy remained in King's College Hospital some time; and Mr. Henry Smith predicted that a portion of either his shirt or his trousers remained in the thigh. An abscess formed, and discharged what proved to be a portion of his trousers, which had evidently been thrust in by the sharp iron and remained behind; on the removal of this the wound soon healed.

Mr. Spencer Watson narrated three similar instances in which foreign bodies had remained for a considerable time in the cheek, the hand, and the eye.

Dr. C. R. Drysdale read a paper entitled

FOR AND AGAINST ANIMAL VACCINATION.

The author of the paper said that, when in Brussels in the month

of September, 1875, he had the opportunity of conversing with Dr. Palasciano, of Naples, and also of hearing much about the great experiment going on in Belgium on animal vaccination. This practice arose in Naples in 1810, in the hands of Dr. Galbiati, and his pupil, Dr. Negri, had since carried it out in Naples, by inoculating calves with lymph, and sending them round, for the charge of five francs per vesicle, to any practitioner in Naples desirous of vaccinating children. One hundred inoculations were made by Negri on each calf, and vaccinations were made with these for a week. Dr. Palasciano mentioned these facts at a congress of medical men held in Lyons in 1864, after the long discussion in the Academie de Medécine of Paris upon vaccinal syphilis, which followed on the work of Viennois on that subject. On hearing the account given by Palasciano, Dr. Lanoix, of Paris, went to Naples and brought back to Paris, in December, 1864, a heifer, aged nine months, inoculated by Negri. From this heifer another was inoculated in February, 1865, and taken by Dr. Ramirez to Brussels, at Dr. Warlomont's request. Since that date, animal vaccination has gained ground rapidly in Belgium. The process made use of is the vaccination weekly of two calves, male or female, of about three months old. Each calf has some hundred vesicles made on its abdomen, and these furnish lymph on the fourth or fifth day after inoculation, so that the calves remain only five days each in the cowhouses of the Institut. The animal vaccine is now not preserved in tubes, as it rapidly decomposes when such is the process used; and it is for this reason that the French do not succeed well with animal vaccination, according to Dr. Warlomont. When vaccine points are used, however, the success is almost constant, even for periods as long as forty-five days after dipping. Over 10,000 persons had been vaccinated by Warlomont before the year 1871, without any disagreeable results; and in no case was there much severe inflammation observed. Evidence was offered by several Belgium practitioners, to the effect that this form of vaccine seemed extremely powerful as a preservation against smallpox, and some of those cited by Dr. Warlomont, in his address at the Academy of Medicine of Belgium in 1871, seemed to think it a better prophylactic than Jennerian or humanized lymph. On the other hand, Professor Crocq and others alleged that there was no superiority in this animal vaccine, except in the fact that it could, in times of epidemic, be multipled at will, so as to inoculate an unlimited number

of applicants. With regard to the question of vaccino-syphilitic contagion, which had been so frequently debated in France and elsewhere, Dr. Drysdale had long been of opinion that the aggregate of facts adduced since the commencement of the nineteenth century could not fail to have convinced any well-informed person as to its reality. Mr. Hutchinson's recent cases (1871), added to those of other observers, too, showed that even healthy looking infants of even three months, might, unless *most narrowly* inspected, prove the source of this infection. It was certainly true, however, that vaccino-syphilitic infection was very rare; and most medical men, doubtless, would agree with him that it was hardly worth while running to animal vaccination for such an uncommon occurrence as this. He thought, however, that in all countries where vaccination was compulsory, it might be as well for the process of animal vaccination to be added to those adopted by the state, so as to afford no excuse for recusants who objected to shelter their children from smallpox. In addition to the plea for the use of animal vaccination by the Government vaccine establishment, he thought that, in sudden emergencies, such as occurred when smallpox was very prevalent, and revaccinations numerous, the power of suddenly creating an unlimited stock of undeniably perfect vaccine matter was a real advantage. Hence he concluded that a great debt of gratitude was due to the Neapolitans and to the Belgians, especially to Dr. Warlomont, for the experiments so successfully made on animal vaccination in Brussels.

Dr. Dowse exhibited an enormous kidney, taken from a woman, æt. 72, who died of right hemiplegia. It formed a large unilocular swelling, occupying nearly half the abdomen, and on being opened was found to contain two quarts of purulent fluid. It consisted of a hypertrophied capsule containing some caseous masses, the renal tissue being almost entirely destroyed.

Monday, November 22nd, 1875.

Dr. Routh, President, in the Chair.

Mr. Francis Mason exhibited a man, æt. 36, who had a tumour

about the size of a walnut at the roof of the mouth. Thirteen years ago the patient noticed a small swelling, the size of a pea, in the centre of the hard palate. It gradually increased in size, and when seen as an out-patient by Mr. Mason at St. Thomas's Hospital, in July last, was as big as a Tangerine orange. The growth had never given the least pain, nor caused the slightest discomfort, until the day he applied for advice, when early in the morning there was smart hæmorrhage, which gave him some alarm. In examining the part Mr. Mason used every care in manipulating the tumour, but the slightest touch provoked hæmorrhage, which being somewhat free, the patient was detained, and admitted into the hospital. He was placed in one of Mr. Mac Cormac's beds, and, by the courtesy of that gentleman, Mr. Mason took charge of the patient. The hæmorrhage was found to proceed from a small ulcerated opening on the right side of the tumour. The bleeding point was carefully stuffed with lint dipped in perchloride of iron, which immediately arrested the hæmorrhage. Subsequently, there was an ulcerated opening in front of the tumour, through which the forefinger could be passed, and the swelling had all the appearance of being of a cystic character. Since the patient has been discharged from the hospital the growth has gradually diminished to its present size, and whatever be its pathological character, whether solid or cystic (Mr. Mason believed it to be cystic), the patient, whose health is excellent, is unwilling to have any operative interference, an opinion in which Mr. Mason himself fully concurs. It was remarkable that, notwithstanding the prominence of the swelling, the voice was little, if at all, impaired.

Mr. Wm. Adams said he had removed a fibroid growth from the hard palate of a lady, æt. 40; the base of the growth was small, and he gouged the bone away. These cases generally did well.

Dr. Thorowgood brought forward a case—

CIRRHOSIS OF THE LIVER IN A CHILD.

Ellen S—, æt. 10, living at Chiswick, was admitted into the West London Hospital, under Dr. Thorowgood, on the 16th October, 1875. Patient began to feel ill six weeks before that date, but did not notice any enlargement of abdomen until October 13th, since which time it rapidly increased in size. She has been liable to cough in the winter, but never had rheumatic, or scarlet fever.

October 16th.—Skin of abdomen tense and shining; superficial

veins visible. Enlargement uniform, and abdomen measuring thirty inches at umbilicus; fluctuation distinct; short murmur at cardiac apex; side rather œdematous; hepatic distress diminished.

17th.—Three pale motions of bowels; conjunctiva jaundiced; urine scanty, high coloured, no albumen. Abdomen thirty-one inches round.

19th.—Iodide of potassium given with nitrate of potash and Tr. Scillæ. Bowels loose.

23rd.—Abdomen thirty-four inches round; pulse 120; bowels freely open; motions yellow.

Shortly after this the patient passed and vomited blood, after which she sank, and died on October 25th, having been seven days in hospital. The liver was shown to the Society. It was in its recent state firm and covered with nodules varying in size. On section much orange-yellow coloring matter was seen. The spleen was large, but normal in structure. The kidneys, and other organs of the body were healthy.

Dr. Leared asked if the parents of this child were drunkards.

Mr. Wm. Adams stated that a cirrhotic liver of a girl, aged 10, is now in the museum of St. Thomas's. The child had hæmatemesis and hæmorrhage from bowels; ruptured lung coexisted here.

Dr. Crisp and Dr. Rogers both considered that large quantities of spirit were given to the children of the lower orders.

Dr. Thorowgood, in reply, stated that in the present case there was no evidence that the cirrhosis was due to alcohol.

Dr. Thorowgood next introduced Mr. Carrick, of Glasgow, who exhibited an inhaler.

The President considered that the portable respirator might be of service to the fire brigade.

Dr. Brunton then read a paper

ON THE TREATMENT OF PERSONS SUFFERING FROM TAPEWORM.

"Where tapeworm affects the human being in this country, it is found to be of three varieties, viz. *Tænia solium* or pork tapeworm, *Tænia mediocanellata* or beef tapeworm, and *Tænia lata*, a comparatively rare species, for the most part introduced or imported from Russia or Switzerland. While the two former worms are met

with in nearly equal proportions, the latter occurs about once in 200 or 300 cases.

Pork and its various preparations, more especially raw or half cooked, is the usual, though not only source of *Tænia solium*, while ordinary beef and veal, of course improperly or partially cooked, is the origin of *Tænia mediocanellata*. The source of *Tænia lata* is similar to the others.

For the natural history of these worms I beg to refer you to the standard works on the subject, and to any of our handbooks of the practice of medicine.

It is sufficient for us, for present purposes, that one of our patients is affected with tapeworm. How are we to diagnose its presence, and deal with it?

The diagnosis of the presence of the worm is dependent upon the symptoms and signs present.

As for the symptoms, they are the most uncertain and heterogeneous of any disease I know of. To generalise these, as presented in a number of cases which have come under my care, will necessitate the relation of a list far outvying the most distressing attacks of hysteria; in fact two of the cases treated by me were diagnosed by others as simply hysteria, and prescribed for and otherwise treated as such. One of the patients thought herself pregnant, and engaged a medical attendant for the expected accouchement.

Of the various symptoms, general derangement of health takes first place, manifesting emaciation, debility, depression of spirits, languor, weariness, flushing, general malaise, pains over the body shifting from one place to another, night sweats, intermittent febrile states simulating ague, formication, and in some cases prurigo. Locally headache, frontal, occipital, or vertical: giddiness, loss of memory, drowsiness, dimness of vision, and sometimes photophobia.

Again, difficulty of breathing, sense of oppression relieved by sighing, palpitation, and globus.

Next, most of the symptoms of dyspepsia, flatulence after food, and in the empty state hiccough, sickness, pain in the stomach and bowels, constant feeling of sinking at the pit of the stomach, even after a hearty meal, loss of appetite, at other times excessive appetite, furred tongue, nasty taste in the mouth in the morning, spasms, sense of something moving in the bowels, irregularity of the bowels, sometimes constipation, at other times diarrhœa.

Again, with many of these dysuria, scanty and high-coloured water when passed, loaded with lithates, at other times precisely the opposite, an abundant or excessive flow of clear liquid urine.

In the female, uterine derangements, such as dysmenorrhœa, amenorrhœa, menorrhagia, or leucorrhœa.

Besides these, occasional cases exhibit itching and convulsions, grinding of the teeth, sleeplessness, irritation of the nostrils and anus, hard dry cough, epilepsy, deafness, and mania.

The symptoms, however, are very various, two cases seldom at any time being alike, and from a detail of these it is evident that they are so anomalous that one would have difficulty in saying what disease a patient suffered from.

But the very anomalous character of the symptoms gives us the cue to their probable cause. Certain anomalous symptoms not observed in other diseases, or not accompanied by those which under common circumstances would appear with them, indicate the probable cause. For example, if a patient come with a short, harsh, dry cough, or pains in the thorax without corresponding dyspnœa or affection of the pulse, and if, on examination, no signs can be found for this cough, one is led to consider it sympathetic, and due to some source of irritation other than in the lung.

For example:

In 1863, Mrs. W—, æt. 30, came to me suffering from severe, hard, dry cough, which she called 'stomach cough.' She had other relative symptoms. She was put under the usual treatment for such cough, principally anodyne. The treatment totally failed, and as she expressed, one day, some dissatisfaction at not being relieved, I asked her if she suffered from tapeworm. She replied that she believed she did, and on evidence being produced, I treated her; on evacuation of the worm there was complete recovery from all her distressing symptoms.

Now, another case in the same year. E. G—, a butcher, was seized with an epileptic attack. I was hastily summoned and found him insensible. His wife said he often had such fits, which she and her husband attributed to an injury he had received to his head two years before. On his left temple there was a long depressed scar, such as one sees after a severe blow, with depression of the bone.

After a time he recovered consciousness, and next day, on asking a series of questions, I elicited that he suffered from tapeworm. I

prescribed for him, evacuated the worm, and from that day till his death, some six years after, he never had another epileptic seizure.

I have related these cases as showing how, in the first the anomalous symptoms led to the diagnosis, and in the latter how easily one could have been mistaken, if the damage done to his skull had been accepted as the cause of the epilepsy.

When I meet with a case of disease which manifests anomalous symptoms, and which is not soon relieved by treatment, I make it a point to ask, "Do you suffer from tapeworm?" If I get a negative answer, I request the patient to take a dose of castor oil, fasting, and examine the stools. On many occasions I have found those who did not imagine they had such an "unwelcome guest," gratified that they had discovered by these simple means the source of their daily misery.

Tapeworm disease will sometimes simulate typhoid fever, and in the cases I now narrate, it was rather curious to find that a strong man (1873) was laid up for a fortnight with fever, quick pulse, typhoid tongue, tenderness and gurgling in the right iliac fossa, and the other signs of typhoid, which I need not detail. He was nursed by his wife, who kept about, and seemed very well. One day, when examining one of his stools, I detected portions of tapeworm, and when I expressed my surprise, his wife said "I suffer too, and pass pieces." I put both under the same treatment, with immediate recovery to the husband from all his distressing symptoms, and relief to the wife from her burden.

If a patient come saying "I pass pieces of tapeworm," on satisfactory evidence that what he passes is tapeworm, the diagnosis is at once certain; but many a time I have had pieces of undigested food, especially tripe, brought to me, which certainly looked like tapeworm segments, but on examination with a hand glass their true character was at once established. It is a safe rule, if a patient think he has a tapeworm to give him an active purgative, fasting, and have his stools examined. Compound powder of scammony, or jalap does uncommonly well, or, in the case of the less robust, a dose of castor oil. When we have segments of the worm presented to us, it is not easy, if possible, to say at first sight whether they be portions of *Tænia solium* or *Tænia mediocanellata*. It is well known that the former has a much greater adherent power to the intestine, on account of its hooked nose, than the latter, which is unarmed. The symptoms with either worm are alike, and the case

requires immediate treatment. From a long and careful observation of the power of the reputed anthelmintic remedies, I came to the conclusion, some years ago, that it was advisable in all cases to administer a combined dose. Turpentine by itself I found a failure, so with male fern, kamala, and the others. Of all the remedies I was most diligent with male fern in repeated small doses, as recommended by Sir Robert Christison, and in large doses as desired by others, and with very varying success. Palliative only in many cases, until, after treating upwards of twenty cases, I adopted the following formula, which I can confidently say (and it has been testified to by others to whom I have given it, with the *proper preliminary conditions*) is an unfailing remedy for evacuating both kinds of tapeworm. I have not met with *Tænia lata* in my own practice, yet I feel certain that it would yield to my formula.

Two drachms of kamala are to be rubbed down in a mortar with as much powder of gum acacia, and a little water, till an emulsion is formed, then, gradually, two drachms of liquid extract of male fern are to be added with careful trituration, so that no separation takes place, water being added drachm by drachm, and the trituration continued till three ounces are made up. *Dose*, half of the mixture at bedtime, and the remainder four hours after.

But, I spoke of preliminary treatment; this part I put as *most essential* to success. It is of the utmost importance that the drug given should reach the worm in as concentrated a condition as possible, and therefore that the bowel should be clear or empty of all digested, or undigested food, and fæces, so that the remedy should reach the worm in good quantity, at a time when the worm is itself in a condition of partial starvation, and ready to absorb that which immediately enters the small intestine. On these grounds I advise my patient, after fasting for a few hours, to take a full dose of castor oil, and starve himself for twenty-four hours of all solid and liquid food (except such liquid nourishment as the stomach will absorb direct, viz. beef tea and a little brandy, as support for the day) then he is to take his draughts as above directed. The kamala purges, so there is no necessity for him to use a purgative afterwards, as many recommend ; the result in all my cases has been the evacuation of the worm, in one or two entire, but never in any case alive.

This prescription, as I have observed, does for both kinds of worm. It has been said, and it has been written, that the discovery

of the head in the evacuations is the only certain sign that the worm has been effectually expelled. I doubt not that such discovery is most gratifying and satisfactory. Yet, in a large proportion of the cases I have treated successfully, I have failed, after long and diligent washing and filtering of the evacuations, to find the head. The tapeworm head, not larger than a small pin's head, if disconnected from the neck, can easily be lost. I believe it comes away dead in many cases some time after the bulk of the worm has been evacuated into the chamber-pot, and so is not discovered. The true test is that if the patient has had the worm expelled, and no sign (by passing portions) returns after a period of four or six months, he may consider himself cured. That is my experience, but a patient once cured may again put himself into the condition of fresh invasion, by applying himself to the cause, in eating uncooked pork, or beef, or other animal containing the germs of *Tænia*. It occasionally happens that a patient is the subject of more than one worm. One may come away entire, leaving another or others behind; but the above test I have proved to be invariably satisfactory.

It may be asked again, why do I prefer the combined dose? My reply is that I have found it answer when all other *simple* remedies have failed. A case for example—

H. P—, a native of Scotland, had been resident at Buenos Ayres for some years. He contracted tapeworm, and was treated there with turpentine, kousso, kamala, and afterwards in Glasgow, London, and elsewhere, with male fern. In May, 1863, he was in town, and, while walking down the street with a friend, he was seized with excruciating pains in the bowels, and was brought to me for relief. I advised him to follow the indications above given, and to take the remedy as prescribed, and he did so with complete relief. I saw him five or six years after; he had no return of tapeworm, and yet, in this case, I failed to find the head. It is, in my cases, quite satisfactory if the worm comes away very narrow and near the neck, then we may assume a cure.

Having given you my own experience as regards the remedies, I may say briefly that those usually employed in the cure or expulsion of tapeworm are turpentine, male shield fern, kamala, kousso, and pomegranate-root bark.

Of these the most reliable are male fern and kamala. No doubt, now and again, turpentine (first recommended by Dr. Fenwick

Durham in 1810) will affect a cure, yet it is so unreliable that, unless one could not obtain any of the more certain drugs, in my opinion, it is then only justifiable to use it. Next in increasing power is pomegranate-root bark. It was used by the ancients as a vermifuge. Celsus, Pliny, and others, speak of it as an anthelmintic, and at a very early period the Indians used it extensively. Though several cases are on record in which the decoction of the sun-dried rootbark expelled tapeworm, yet its uncertainty has caused it to give way to the following three remedies :—

1. *Kousso,* the flowers and tops of *Brayera anthelmintica,* a native of Abyssinia. The remedy is bulky and is not cathartic. Its powers have been greatly lauded, and I have seen several cases successfully and unsuccessfully treated with it. I have no experience of the crystallizable principle koussine.*

2. *Kamala,* imported from India, and introduced by Dr. Leared to use in this country, and holding great repute as a vermifuge. It consists of a brick-red granular powder, composed of the minute glands which adhere to the capsules of *Rottlera tinctoria.*

Lastly. *Male shield fern,* the dried rhizome (summer-gathered) of the *Aspidium filix mas.* It is sometimes administered in the form of powder, and as such enters largely into most of the worm-cake nostrums. For further particulars of each of these drugs reference can be made to any of our standard works on materia medica, and therapeutics, such as Pereira, Christison, Garrod, Ringer, &c.

To ensure success in the treatment of any case it is absolutely necessary that the drug made use of, whatever one selected, be perfectly fresh, and newly prepared. As I stated when I read my paper on the therapeutic use of aconite, how necessary it is to get the true herb—the *Aconitum napellus*—for there are many aconites—and also how necessary it is, in order to obtain all its virtues, that the root be gathered at the *proper season ;* so, while our drugs must be fresh or recent, they must be obtained at the proper season, and this particularly must be said of male fern. Its therapeutic power is very much diminished if it be gathered other than in the end of the summer, and the early autumn months. I am sure that many of the failures met with in practice are due to pharmaceutical neglect. It is just as important for the physician—nay, more so—to have his weapons in the best order, and of the best

* Since writing this I have tried koussine in two or three cases, with total failure even to expel any portions of the worm.

prepared material, as it is for the surgeon to wield the finest steel which has been been contrived into the most ingenious, and handy instrument. This point I insist upon as most essential to all practice. Need I say that no man can make accurate observations regarding the therapeutic value of any drug, unless he use the pure, unadulterated, and scientifically prepared article. While most inorganic drugs, and chemicals, stand long unaltered, and unchanged, those of the vegetable and organic class, after once they have been prepared for use, for the most part chemically decompose, and lose their active properties. Light, air, moisture, heat, cold, change of temperature, seriously affect them, and, just as the surgeon discards a rusty knife, so ought the physician to abjure a musty drug. Depend upon it, we cannot do our work, as it ought to be done, if we use bad materials.

But, there is another important point to be observed; when intestinal worms prevail, there is usually an unhealthy condition of the mucous membrane. There is super-secretion of mucus of abnormal quality, which forms, not only a favourable bed for the development and growth of the worm, but also an obstruction to their starvation. This is manifested by the excessive quantity of viscid mucus which comes away in the stools, after the administration of the anthelmintic drugs. It becomes necessary, therefore, after the expulsion of the worm, to treat the general, relaxed, and unhealthy condition of the bowel, and that is best done by the administration of general tonics, such as the various preparations of iron, combined with vegetable bitters, strychnia, calumba, quassia, gentian, and the like. My opinion is that intestinal worms do not find a comfortable habitat in the healthy individual. Though their presence does always manifest a depressed state of health, I think a previously disordered condition is more favorable to their existence. In order to avoid the invasion of such unwelcome guests it is absolutely necessary to see that our animal food is well and properly cooked.

In conclusion, I may remark that the action of the remedy in my hands has not been accompanied by the nausea, and distress, which has been so often mentioned by other writers, and the reason for this, I believe, is that I invariably administer the remedy at bedtime, or, rather, order the patient to take the dose after getting into bed, and to immediately lie down. In this way the nausea may be avoided, at least, I have found it so in an experience of very many cases.

Above all, see that the drugs used are fresh and well prepared, else the result of the administration will be unsatisfactory and disappointing."

Dr. Fothergill had poisoned a tapeworm with lead and opium, administered for persistent diarrhœa.

Dr. Leared first introduced kamala into practice here; it was much used in India, and is now a patent medicine. The late Mr. Hanbury found that the male fern oil from Germany was bad; hence many failures of this drug. Mr. Quekett used to show portions of sheep's aorta, passed as false worms. Kamala acts well as a tincture; he had known death to result from giving turpentine as an anthelmintic.

Dr. Crisp, after experiments with kousso, male fern, and turpentine, thought the latter the best, but now he prefers male fern; duck-stuffing acts as an anthelmintic. Salt is useful.

Dr. Thorowgood thought that onions and assafœtida were anthelmintic.

Dr. Farquharson considered the beef-worm as common as the pork-worm. In Abyssinia Dr. Currie lauded the male fern.

Dr. Godson narrated the case of a child who passed twenty-four yards of tapeworm, and had such a craving for salt that she swallowed every particle she could lay her hand upon, so that it had to be placed out of her reach.

Dr. Griffith suggested the use of perchloride of iron.

Dr. Brunton replied, and, in answer to Dr. Williams, said that a patient who suffered from tapeworm, and was anxious to be rid of it, never objected to the preliminary treatment, which he always insisted as essential to success.

Monday, November 29th, 1875.

Dr. Routh, President, in the Chair.

Dr. De Gorrequer Griffith exhibited

A CASE OF HERMAPHRODITISM.

A woman came to the Hospital for Women and Children, saying that her child was wasting away. In the course of examining her

as to the probable cause, she said it might be owing to there being something wrong with the privates. On looking at the parts, a casual glance would give an opinion that there was little the matter, except that, what would be taken for scrotal integument seemed more to resemble labial. On raising the apparent penis—since the organ most closely resembled it—no opening was found permeating its entire length, but on drawing it upward, and forward, a urethro-vaginal looking orifice, from which the urine was expelled, came into view, through which, and running back for about two inches, could be passed a catheter that could be felt per rectum, plainly, not in a vagina, but in the bladder.

The bi-lobed appendages lying on each side of the apparent penis did not look like scrotal tissue, but more closely resembled the labia, and the difficulty of affirming to which sex the little one belonged, was increased by the fact that the testes had not descended, nor could they be felt by the finger in the bowel, nor by deep seated pressure through the abdominal walls.

It was difficult to say whether the cavity into which the instrument gained entrance, through the urethro-vaginal looking orifice, was the bladder or a vagina; this might be decided by enlarging the opening; however, assuming the lateral bi-lobed structures to be the external labia, two other lesser labia might be brought into view by pulling up the penis, or clitoris. Were these in reality labia minora, or were they folds of a true hypospadias? Some who have seen the malformation consider the child to be a female; but its parents have had it registered as a boy.

The 'Transactions of the Obstetrical Society,' record no case of hermaphrodite, and, therefore, the author considered this sufficiently rare to lay before the Society:

1st. Because such a condition of the genitals is not common.

2nd. That the Fellows might give an opinion as to the advisability of remedial measures.

He read a quotation of a similar case from page 221 of Simpson's 'Midwifery.'

Dr. Routh, after careful examination, considered this was a female child. No testes could be found.

Mr. J. S. Wilkinson considered it was a male. He mentioned a case recorded by Professor Wood of a person who had been married three times to three men, and who at the post mortem turned out to be a male.

Dr. Crisp stated that a similar case to Professor Wood's had been described by Dr. Clutterbuck.

Dr. Rogers thought the child a male. A deputy-inspector general of hospitals and fleets, at Jamaica, passed during life as a man; eventually the post mortem proved this individual to be a woman. As a man she had gained great distinction in Her Majesty's service.

Dr. Griffith replied, and Dr. Wiltshire and Mr. Davy were appointed as a committee to examine this case carefully with Dr. Griffith, and to report thereon.

Dr. Crisp then read a paper on

A RECENT EPIDEMIC OF SCARLATINA, EPIDEMIC SORE THROAT, AND ERYSIPELAS, WHICH OCCURRED CHIEFLY IN JUNE LAST, IN THE S. W. DISTRICT OF CHELSEA.

The peculiarity of the epidemic was the large number attacked almost simultaneously, and its general mildness, and unfatality, as regards scarlatina. A table of ninety-eight cases seen by Dr. Crisp in June was appended, forty-two of these being generally mild cases of scarlatina, and fifty-six of what Dr. Crisp called epidemic sore throat, all the patients in the latter affection, with six exceptions, being over twenty years of age, the majority of them having had scarlatina. The invasion of the disease was generally sudden, beginning mostly with stiffness at the back of the neck, chills, and fever, with depression of power, the tonsils enlarged and inflamed, generally without abrasion or creamy patch. In many cases the glands of the neck were much swollen, so that the head for a few days was almost immovable. There was no eruption, or desquamation of cuticle, nor did the white tongue with red tip and raised papillæ exist. In one example only, in which abscess occurred in the leg, the tracheal obstruction with loss of voice was so formidable that tracheotomy was contemplated. One case only, in a lady sixty years of age, proved fatal, and this was from an accidental fall against the bed post. The patients, as in the scarlatina cases, were all in good circumstances, and very little of the disease, as shown by the reports of the parochial surgeons, was seen among the mechanics and poorer classes. None of the cases of scarlatina were fatal; they were unusually mild, and rarely attended with any kidney complication, and there was this remarkable contrast between scarlatina and

epidemic sore throat as regards age, that, whilst in the latter only six of the fifty-six patients were under twenty years of age, in the former (scarlatina), of the forty-two cases, only seven were above that age.

The disease was confined chiefly to Chelsea, to an area along the river of about half a mile in length, and 500 or 600 yards in breadth. The general state of the drains, the opening of the old sewer at the end of Beaufort Street, and the deposit of sewage upon the mud of the river, were supposed to have been the chief causes. Erysipelas prevailed to a great extent. Dr. Crisp had seen eight cases in June, Mr. Thurston four in June, and Mr. Keen ten from the 28th of May to August 10th, and many other examples were known to have occurred (including several deaths); six of these were in infants after vaccination. During this period the general mortality was below the average, as in nearly all parts of London.

Dr. Buchanan thought that the method of spread of erysipelas, sore throat, &c., required investigation. He had reason to suspect that a certain cream supply had been concerned in the spread of scarlet fever, but the evidence was as yet inconclusive.

Dr. Williams supported this view, and stated that drains and water were pure, notwithstanding that scarlatina was rife.

Mr. Milton stated that scarlatina has been increasing in severity since the days of Sydenham, although sewage works in London are more complete now than then. How can we account for the scarlatinal outbreak in isolated houses? The milk supply was not the cause of the present epidemic, because St. George's Hospital was supplied by the same source as many of these patients.

Dr. Fothergill drew attention to scarlatinoid forms of blood poisoning. Scarlatina in the country was one thing, and scarlatina in the town another.

Mr. MacDonagh mentioned that Sir W. Jenner, as a young man, invariably had sore throat when attending scarlet fever.

Monday, December 6th, 1875.

Dr. Routh, President, in the Chair.

Mr. Maunder brought forward

A CASE OF EXCISION OF THE ELBOW-JOINT.

The author said it would be in the recollection of some members of the Society that he had on more than one occasion exhibited patients illustrating his method of performing excision of the elbow-joint. The object of this was to secure, *with certainty*, active extension by the triceps muscle. He had stated elsewhere ('Maunder's Operative Surgery,' second edition, p. 122), "It is, however, probable that in exceptional instances the cut triceps acquires attachment to the end of the ulna through the medium of fibrous tissue formed during repair. By this means some amount of extension is secured, but it is *accidental* and cannot be foretold in an individual case."

He now showed the patient in whom the method which he strongly advocated first suggested itself to him. Henry E—, aged twenty-eight, admitted November 20th, 1868, into the London Hospital under his care. His left elbow-joint had been comparatively useless from pain and swelling for the last two years. His symptoms were now greatly aggravated, and the operation was determined upon. December 12th, 1868.

He made a longitudinal incision along the back of the arm, the point of the olecranon corresponding with its centre. Having separated the triceps from this process of bone, and carried the ulnar nerve to a place of safety in front of the internal condyle, he was about to sever the structures lying between the external condyle and the olecranon, in order to facilitate exposure of the bone ends, when he found that the outer portion of the triceps muscle, with its tendinous prolongation, the fascia of the forearm, and the anconeus muscle, could be readily lifted and preserved in one piece. He remarked, at the time, to his colleague Mr. James Adams, that active extension by the triceps would thus be secured to his patient. The observation of this case led Mr. Maunder to the

dissecting room, and he there confirmed his opinion of the value of preserving in one continuous band the structures above named.

In conclusion, and to avoid error, he would make one more remark.

Surgeons have said to him "Your method is by longitudinal incision, is it not?" His answer was Yes, but the longitudinal incision refers to the deeper structures and not to the skin. This latter you may sever in any way you please, whether by ⊣ or H incision, or any other device.

Thus, accidentally, to him as to others, new methods of operation might occur.

Dr. Robert Lee then read his paper on

DIFFERENT FORMS OF PESSARIES.

The author, after some preliminary remarks, asked his hearers to imagine themselves engaged in the construction of a pessary; that, without any knowledge of what has been invented, they are attempting to treat an ordinary case of procidentia uteri, where the uterus is so low in the pelvis that the os uteri is external. "If we examine a pelvis from which the soft parts are removed, except the ligaments, we shall see what points are presented internally on which to rest any rigid body. We have to deal with a curved canal of considerable dimensions, increasing in size from the orifice inwards, and we may therefore conceive that we might insert this rigid body in such a way as to find support upon some of the bony parts. Thus, if the ischial bones are slightly inclined towards one another, we might be able to fix upon either side the ends of a supporting structure, by stretching it across between them. There would seem to be a possibility of doing this more easily if we were to take advantage of the oval foramina, which are covered with a tissue which yields slightly to pressure. But this brings us at once to the consideration of the pelvic coverings, the tissues which are interposed between the canal of the vagina and that of the long pelvis; and we are obliged to allow that no rigid body could be inserted laterally, in the way I refer to, without using very considerable pressure. We are now in a position to judge of the extent to which we could apply all kinds of pessaries which extend laterally across the vagina, such as that of Schwank's, which is, no doubt, familiar to all of us. By measuring the distance between the extremities of

the wings of Schwank's pessary we could tell at once whether this was likely to be in contact with the ischial surfaces, and we could judge to what extent its supporting power would depend on the bony walls of the pelvis. If we now pass on to that large class of pessaries which are simply intended to dilate the vagina, whether they be globular or oval spheres, or more or less flat or oval discs, comparing their diameter with that of the pelvic orifice, we could tell whether they would be far from, or near to the bony walls. All those in use, however, are of such a size as simply to dilate the vagina, and it must be evident that there is no possibility of these being retained under the soft parts at the orifice from a constriction which prevents their escape. Supposing that we allow that there is some rigidity of the soft parts, particularly laterally, the mechanical advantages of a disc, as compared with a sphere, require to be considered. Theoretically, the amount of resistance which a disc would present to pressure from above would be the same, provided it were of a certain thickness, with that of a globe, for the globe only comes in contact with the vaginal walls around its circumference, so that we can decide how far one of this class of pessary is superior to others. It is necessary to remember that the nature of the surface of the globe or disc must be taken into account, for the friction between the vagina and the pessary will depend on the roughness of the latter, to use a common term. This point involves the question of the physiological structure of the mucous membrane of the vagina, in order to avoid the not uncommon occurrence of ulcerative inflammation. Thus we see that we have to consider the problem mechanically, anatomically, and physiologically. The mechanical question becomes more important when we endeavour to ascertain to what extent we can take advantage of the pelvic curve, and attempt to find some rigid support, not between the ischial bones, but in the transverse direction, between the symphysis pubis and the sacrum. If we can insert a rigid body in this position, the length of which is greater than the diameter of the distended vagina, and can fix the lower extremity of it, it may be possible to obtain what we desire; and on this principle, to some extent, I conceive, Hodge's pessary is intended to act, but in such cases as that which I first selected, where the uterus is so low down as to be partly external, we find no support whatever from any part of the pelvic bony canal, and we are compelled to resort to some other means to retain the uterus in its place. By this brief analysis of the question

I have indicated the different conditions which must be borne in mind in the choice of a pessary, and it was this view of the whole question that I placed before Mr. Napier, when I asked him to apply his mechanical knowledge to the construction of a pessary. More than a year and a half since, and not long after, quite independently of my request, Mr. Henry Lee suggested to Mr. Napier the possibility of making use of the same principle on which Mr. Napier's catheter had been constructed, for a uterine pessary. Although my own attention has been directed to different subjects since that time, I could not deny myself the pleasure of introducing to you the result of this attempt of Mr. Napier to carry out the suggestion he had received."

Mr. Napier stated that he had introduced the pessary shown, following up the idea of his convolvolus catheter. Mr. Henry Lee had subsequently hit upon the same idea. He considered his form of pessary the best, and preferred an elastic to a solid column of support in the vagina.

Mr. Henry Lee advocated support from the shoulders instead of around the pelvis. Pressure on the vagina induced paralysis of its muscular wall. He stated that this pessary answered where others failed.

Dr. Godson said that Napier's pessary was similar in form to one he was in the habit of using occasionally at St. Bartholomew's; he preferred Schwank's, on account of the objection patients had to external straps.

Dr. Routh stated that this pessary was not new. In pure procipentia pessaries did good service; but ladies disliked external straps. In procidentia complicated with rectocele or cystocele the pessary would be forcibly pushed out. Ladies can carry a properly fitting pessary without inconvenience. Mr. Napier's idea was ingenious, but not likely to supersede others, as Schwank's or Hodge's.

Dr. Robert Lee then replied, and agreed with the President that this pessary should be further tried, and he hoped that future experience would show its value.

Monday, December 13th, 1875.

Dr. Routh, President, in the Chair.

Dr. Henry Lawson exhibited an apparatus for measuring blood-corpuscles numerically by Mr. Hayems. The instrument, called a hæmatometer, consists of a slide prepared to contain liquid of barely the one fifth of a millimètre in depth; then the eye-piece of the microscope, beneath which the slide is placed, is provided with a micrometer, in which the one fifth of a millimètre is squared and divided into sixteen equal spaces.

Ordinary blood is not used because, if it were, the corpuscles would be vastly too numerous to count. Therefore, by a specially measured instrument two cubic millimètres of blood were taken, and they immediately mixed with half a cubic centimètre (or 500 cubic millimètres) of serum in a special glass. Having thus been sufficiently diluted, a portion of this mixture is placed in the slide, so as exactly to fill it.

Mr. Freer then read a case of

VAGINAL IMPALEMENT; DEATH FOUR YEARS AND A HALF AFTER.

This case, as far as the history of the accident and its immediate consequences went, was read before a meeting of the London Medical Society in 1871. A summary of the case as a whole is now given.

At 6 p.m., Aug. 9th, 1870, an Irishwoman, aged thirty-four, playfully jumped off a corn rick; unfortunately she alighted on the round thick end of a hay fork which some one had left standing against the stack. The farmer pulled it out of her body some two feet with difficulty. She was brought home in an open carriage, a distance of three miles.

At 8 o'clock I visited her. She was suffering from extreme collapse, and crying out that the spike had hurt her heart. Much blood was lying on the floor. Examining her per vaginam as she lay stretched out, I found bleeding going on from a ragged rent by the side of the uterus, through which I could pass two fingers into the

peritoneal cavity. I plugged at once with long strips of lint, and the bleeding at once ceased. I found also in the left side, where she complained of dreadful pain, an emphysematous crackling and swelling of the skin as high as the axilla, and felt also the crepitus of a broken rib. She was in such imminent danger of dying that she was obliged to be left lying on the floor as she was all night.

Next morning she had got over the shock, and now, and for the next five days, symptoms of intense pleurisy of the upper and back part of the left side appeared, attended by enormous quantities of frothy bubbles proceeding from the mouth.

The lint strips were removed on the fifth day. A dose of castor oil was given at her request, which acted well. From this date rapid improvement took place, and on September 3rd the woman was down stairs washing her table, laughing, and declaring herself quite well, only "a bit weak." Sixteen months after she was confined with a fine boy without help, and soon returned to her field work, which she carried on three miles from her home until the beginning of February, or the end of January, 1875. She was now far advanced in her fourth pregnancy (she had had two children before the accident), and complained of pain in her side and of her breath, and also of constipation and sometimes sickness. Mr. George Birt saw and prescribed for her occasionally, and she found relief when her bowels had been moved by saline purgatives.

On March 2nd he was sent for with the author. Labour had set in during the night and a midwife had been fetched, but the patient was evidently dying; no pulse, incessant vomiting, whispering voice, labour-pains gone, but a fœtal head ready to press on the perineum. No delivery was made, and she died in two hours.

The post-mortem revealed a thin uterus containing a large male child, a contracted state of rectum and descending colon—a roundish hole through the muscular part of the left wing of the diaphragm, just in front of the central tendon. The transverse portion of the colon, the greater part of the omentum, the sigmoid flexure of the colon, a little of the duodenum, the whole of the stomach had passed through this rent and were lying in the left thoracic cavity.

The intestines were bound down by strong adhesions to the upper edges of the opening, some of the colon being of a dark mulberry colour.

The left lung, compressed upwards and backwards, though small was healthy, and contained plenty of air. Old adhesions at

its apex and one strong band stretched across the colon from the anterior margin of the rent in the diaphragm to the base of the lung.

The heart was displaced to the right side of middle line of sternum.

With difficulty the hernia was reduced, and then the opening in the diaphragm could be seen to be through the muscular part of the left wing, just in front of the central tendon. The hole was round, about $1\frac{1}{2}$ inch in diameter.

An old fracture of the fifth rib (well united), just in front of the angle. Going back to the uterus, to the exact spot where actual lesion first occurred through penetration of the stale of the fork, all that could be found was a broad dark line somewhat thicker than the surrounding tissue, in the substance of the left broad ligament close to the uterus which we were obliged to conclude was the cicatricial mark.

The examination was made under difficulties, and no removals were allowed.

In reviewing this remarkable case it seems very probable that at first only the stomach, with the first portion of the duodenum, and a portion of omentum, escaped into the thorax, and that these continued to perform their functions in their new abode because they received no constriction through the rent in the soft muscular part of the diaphragm.

So, for years all went on smoothly, until the abdomen, being for the second time filled with a gravid uterus, a fresh intrusion of abdominal viscera into the chest took place.

Dr. Routh thought it extraordinary that the blood extravasated into the peritoneum had not given rise to septicæmia. He considered it bad treatment to have stuffed the wound with lint; probably the blood lost at the time of accident averted peritonitis. He thought the induction of premature labour would have been undesirable, as the diaphragm would be fixed, and more intestines would be pushed by the abdominal muscles into the thorax.

The report of the subcommittee appointed November 29th to examine the case of hermaphroditism was read. The conclusion arrived at by Dr. Wiltshire was that the subject was masculine.

Monday, December 20th, 1875.

Dr. Routh, President, in the Chair.

Dr. Lauder Brunton read a paper on

THE PHYSIOLOGICAL ACTION OF ALCOHOL.

Is alcohol a food or a poison? Is it one of the greatest boons ever given to mankind, or one of the greatest curses wherewith they are afflicted? These are questions to which we will receive different answers, according to the circumstances under which they are asked. If we ask the man who has just watched by the bedside of his dearest relation during the crisis of a fever, and seen the parched tongue grow moister, the delirium lessen, the quivering pulse grow stronger and steadier under the influence of alcohol, he will probably tell us that if not a food of the same kind as bread and beef, it is, under certain circumstances, better than either, and a blessing whose greatness can hardly be over-estimated. If, on the other hand, we address ourselves to the squalid wife of a drunken husband, who, instead of employing his time in work, and properly spending his evenings, lies in a state of idleness and incapacity for one half the week, and spends the greater part of the wages he receives for the other half in brutalising himself at a gin-palace, we shall probably hear that it is the greatest curse upon earth, a poison destroying soul and body; and that but for it she would be a happy woman, instead of a trembling slave, living in constant fear of blows or death, her husband would be a respected member of society instead of a brutal coward, and her home a paradise instead of a pandemonium.

If we inquire why people drink it at all, the answers we receive are no less contradictory. The negro sweltering under a tropical sun drinks it to cool himself; the London cabman shivering at his stand on a wintry morning drinks it to warm himself; the weary traveller drinks it to strengthen his flagging muscles, and help him onwards to his destination; the literary man drinks it to give subtlety to his intellect, or brilliancy to his wit; the overworked

man of business drinks it to rouse him from his apathy, and give sharpness to his bargains; the gamester quivering with excitement drinks it to steady his trembling hand; and the man or woman broken down by misfortune, and weary of life, drinks it to drown care in temporary oblivion.

Irreconcilable as these answers to our questions may seem, we nevertheless know that they are all more or less true; and, in studying the physiological action of alcohol, our endeavour must be to discover how it is that one drug can produce such opposite effects. This is undoubtedly a difficult task, and one which we cannot at present hope to accomplish perfectly. All that we can do is to take the facts we find, and arrange them to the best of our ability, trusting to future research for information on those points of which we are now ignorant. In doing this we must bear in mind that alcohol has a threefold action. 1st. Its local action on the skin, or mucous membrane, with which it comes in contact. 2nd. Its reflex action on other organs, through the sensory nerves of the skin or mucous membranes. 3rd. Its action on the brain, spinal cord, and other organs to which it is conveyed by the blood.

The action of alcohol is modified, too, by the degree of concentration in which it is employed, and by the admixture with it of other substances, such as ethers of various kinds, hops, vegetable acids, &c. Thus, if we moisten the skin with pure alcohol, in the form of eau de Cologne, or diluted with its own bulk of water, as brandy, and allow it to dry spontaneously, a decided sensation of cold will be produced; but if we employ it in a still more diluted form, as wine or beer, the cold will be much diminished, or become quite imperceptible. This cooling action is due simply to the volatility of alcohol, which during its evaporation abstracts heat from the skin and cools it down. If pure it evaporates quickly, and produces much cold, but, if mixed with much water, the evaporation of the mixture is too slow to produce any marked result. Any other volatile substance would have a similar effect, although its other actions upon the body might be utterly different from those of alcohol.

And, indeed, we get a very different result from alcohol itself if, instead of allowing it to evaporate spontaneously, we prevent evaporation altogether by covering the moistened skin with gutta percha tissue. Instead of coolness we get a burning feeling, most intense if we use pure alcohol, or eau de Cologne, less with wine, imperceptible with beer. We have got rid of the action which

alcohol owes to its volatility, and we have brought into play another which it owes to its chemical properties. So long as it could evaporate readily it acted almost entirely on the epidermis, but when evaporation is prevented it soaks through the epithelium, and acts on the vascular tissues beneath. This is better seen if, instead of applying the alcohol to the skin, where the epidermis presents a considerable resistance to its passage, we put it into the mouth, where the thinner epithelium offers less obstruction. Almost immediately after its introduction we experience a burning sensation, which increases for a little while, and then gradually diminishes. If we keep it in the mouth long enough, we notice that the mucous membrane changes its character, and becomes whiter, more opaque, and somewhat corrugated. Although the burning feeling appears to be accompanied by an increased flow of blood to the part, and its disappearance by a diminished flow, yet it is not due to the warmth of the blood, for water at a temperature much above that of the blood produces no such feeling in the mouth. Both the sensation of burning, and the visible alteration in the mucous membrane, are due to the action of the alcohol upon the tissues, and we shall better comprehend the nature of this if we compare it with that of other substances. A piece of hot metal, or a solution of corrosive sublimate, will also cause a burning feeling, and an alteration in the mucous membrane, but, instead of being transitory, it will be more or less permanent. Now there is one point in which they all agree, viz., they all coagulate albumen; and the whitened appearance of the mucous membrane of the mouth, after brandy has been long applied to it, is no doubt due to the precipitated albumen on the surface, obscuring the red colour, which the circulating blood imparts to the tissues beneath. But there is this great difference between the action of alcohol and that of heat, or of corrosive sublimate; the latter produce permanent coagulation, while the coagulum formed by alcohol readily dissolves again in water, or in the liquids of the body.* Thus its action is more transient; and, if it be only allowed to act for a short time, its effect is counteracted by the blood which dissolves the albumen as fast as it is coagulated, so that we do not see any opacity of the mucous membrane of the mouth,

* The coagulation of albuminous fluids by alcohol seems due in the first instance to the simple abstraction of water, and when this is again added they re-dissolve. If the alcohol acts for a long time upon them, however, their constitution seems to undergo a change, and they become insoluble in water.

unless alcohol has been acting on it for a good while. When frequently applied to the skin, and allowed to evaporate, it seems to act on the epithelium and harden it, and thus it is frequently used to prevent the formation of bedsores and cracked nipples.

Most substances which possess the power of coagulating albumen, such as tannin, catechu, kino, logwood, sulphate of copper, sulphate of zinc, &c., act as astringents when taken internally, and even corrosive sublimate, although not usually reckoned among their number, is strongly recommended in some forms of diarrhœa by Professor Sydney Ringer. Alcohol is no exception to the rule, and we all know that a person suffering from an attack of diarrhœa usually flies to the brandy bottle for relief before he thinks of consulting a medical man. We know too little about the action of astringents to say positively that alcohol owes its efficacy in this respect to its power of coagulating albumen, but we certainly can say that this property appears to be the only one it possesses in common with catechu and kino.

The simple experiment of putting a little brandy in the mouth is instructive not only by showing us the local changes which alcohol produces in the mucous membrane, but by reminding us of the second kind of action which alcohol exerts, viz. reflexly through the nervous system. At the same time that the burning is felt the saliva begins to flow copiously into the mouth. The alcohol has not come in contact with the salivary glands at all, but through the sensory nerves of the mouth it has acted on the nervous centres and through them upon the vessels and secreting cells of the gland. If we swallow the brandy instead of ejecting it, the feeling of warmth which we experience along the course of the œsophagus and in the stomach itself informs us that it acts on the mucous membrane of these organs in the same way as on that of the mouth. So far as I am aware, we are at present ignorant of the reflex actions which alcohol exerts through the mucous membrane of the œsophagus, but those which it produces through the stomach are of great importance. First of all come those which concern the secretions and movements of the stomach itself. When the stomach is empty its mucous membrane, as seen through a gastric fistula, is pale, and only covered with a little mucus. If a little alcohol be now introduced, the blood-vessels of the mucous membrane dilate, and it becomes of a rosy red colour, its glands begin to secrete copiously, beads of gastric juice stand upon its surface, become larger, and larger, until

they can no longer preserve their form, when they coalesce, and run down together in a little stream.

Now, every slight stimulation of the stomach seems to be felt as appetite, and thus we find that substances having the most diverse properties induce a desire for food. Alcohol does this in a marked degree, and a nip of brandy is very frequently taken as an appetiser. But, appetite seems really to be only an expression of slight uneasiness on the part of the stomach. It cannot distinguish sensations like the mouth, and alcohol, which on the tongue causes burning, quassia, which causes bitterness, and minute doses of arsenic or tartar emetic, which would cause congestion if they stayed in the mouth as they do in the stomach, all cause appetite. Perhaps they do this only by exciting a certain amount of congestion in it, for food itself causes the vessels of the mucous membrane to dilate, and its glands to secrete, in the same way as we have described after the injection of alcohol, and we all know that a person, who begins a meal with no appetite at all, often eats with zest after the first bite, and finishes with astonishment at the amount he has consumed. But, if the irritation be too strong, the whole condition becomes changed.* The mucous membrane loses its rosy hue, and becomes pale, the secretion of gastric juice ceases, while that of a slimy mucus is increased, appetite disappears, and is replaced by nausea, and finally vomiting occurs. This change is often clearly seen in a so-called bilious attack, where the irritation of the stomach first manifests itself as an abnormal craving for food, which gives place, as the irritation increases, to nausea and vomiting.

Now, the amount of irritation necessary to produce these totally different conditions of increased secretion with appetite, and diminished secretion with nausea, varies in different stomachs, and in the same stomach under different conidtions. If the stomach be sensitive an irritation will cause nausea which would only produce appetite if it were less irritable, and *vice versâ*, a sluggish stomach will be benefited by an amount of irritation, which one, normally sensitive, could not bear. Thus we know that in some cases articles of food, such as lobster, which in normal stomachs frequently cause indigestion, and nausea, are readily digested while ordinary food is not digested. The stimulus which an ordinary diet gives to the stomach seems here to be insufficient to excite the secretion of

* Bernard, 'Archive d'Anat. Gén. et de Physiologie,' Jan., 1846, quoted by Power; and Carpenter's 'Physiology.' Ed. p. 149.

gastric juice, while the more irritating substances do so, and are digested, instead of causing over-irritation, and vomiting, as in the normal condition. But if this explanation be correct, how is it that we take a glass of spirits with our lobster "to digest it"? Is not this adding fuel to fire, and increasing the irritating effect of the lobster on the stomach by that of the alcohol? By no means—the fibres of lobster are probably in themselves no more irritating than fibres of beef, but only less soluble in gastric juice, so that they retain their form, and hardness, instead of being reduced to a pulp, and by thus exerting for a longer time a mechanical irritating action upon the stomach they produce nausea and indigestion, not immediately after they have been swallowed, but in the course of some hours. If, however, an increased secretion of gastric juice be produced by means of a glass of spirits swallowed at the same time with the lobster, we may expect that digestion will take place more rapidly, the fibres will be dissolved, and the prolapsed irritation of the stomach being avoided no nausea will ensue.

If insufficient stimulation of the stomach then do not induce a flow of gastric juice, and if excessive stimulation cause nausea, under what circumstances is alcohol likely to be useful? Healthy stomachs with ordinary food do not require it, although in small quantities it may do little harm, and as an adjunct to lobster may be positively beneficial. A large quantity, however, is certain to be injurious. Moreover, if regularly used, even in small quantities, the stomach may become habituated to it, and refuse to respond to the stimulus of food alone, unless supported by that of alcohol. The case is different when we have to deal with a stomach whose sensibility is below par, either permanently, or temporarily. In patients convalescent from an acute illness, or weak delicate anæmic persons, the food does not sufficiently stimulate the weakened stomach, the secretion of gastric juice is small, and the meal lies for a long time like a weight at the epigastrium. The same is the case with the merchant, the lawyer, or the doctor, who comes home from his counting-house, his office, or his rounds, and sinks exhausted into his easy chair, weary and worn out by a long day's work. In such cases the diminished sensibility of the stomach must be compensated by an extra stimulus, and the glass of sherry which to a healthy person, not exhausted by over fatigue, would be superfluous, will in them restore the normal equilibrium, and quicken the otherwise slow and imperfect digestion.

I do not mean to discuss the wisdom of these men's conduct in thus exhausting their energies, or the question how long such a course can be pursued without ending in an utter breakdown, for it is in many instances sheer necessity which drives them to it, and no remonstrance or warning is of any use. But I would say a word about the amount of stimulants to be employed, and the probable effect of excess on the stomach itself. Not only does the sensibility of the mucous membrane become blunted, so that it no longer secretes gastric juice, in proper quantities, when stimulated by food alone, but it secretes mucus in large quantities, and this not only impedes digestion, but facilitates fermentation, by which various injurious substances are formed. Amongst these may be mentioned butyric acid which causes an acrid burning sensation in the stomach itself, and may, according to Otto Weber, and Senator, be absorbed into the blood, and there act as a nerve poison, still farther reducing the business capacities of the unfortunate patient, which may already have been sadly diminished by overwork, and inability to assimilate proper nourishment.

While, then, it may be very beneficial to take a moderate quantity of alcohol with meals, an excessive amount will be injurious to the stomach itself, not to mention its action on the nervous system.

In connection with this power of the stomach to adapt itself to the stimulus it ordinarily receives, I may mention that in one part of the Austrian empire the peasantry live almost exclusively on a mixture of oatmeal and water, which is allowed to ferment and become sour. Although this diet would in all probability so irritate the alimentary canal of any ordinary person as to produce vomiting and diarrhœa, these people thrive upon it and are very strong and healthy. When the young men, however, enter the Emperor's army, and come to Vienna, where they get well-cooked food, they nearly all suffer from indigestion, lose flesh, and become weak and ailing—exactly the contrary of what one would have expected. Of course various explanations may be given of this fact, but I am inclined to believe that the indigestion is due to the well-cooked food being less irritating than the sour meal, and not sufficiently stimulating to the stomach and intestines accustomed to the other.

Alcohol taken into the stomach increases the movements of the organ as well as its secretion, and, by mixing its contents more thoroughly with the gastric juice, accelerates digestion. At the

same time it causes the expulsion of gases, and a little brandy is one of the carminatives most commonly employed by those who suffer from flatulence. But in this respect also the stomach after a little while becomes accustomed to the stimulus, and those habituated to the excessive use of alcohol not only suffer from flatulence due to the process of fermentation already mentioned, but are less readily relieved by the usual remedies.

Dr. Broadbent considered that, in the use of alcohol, time, circumstance, and amount were important factors. Alcohol prevented due oxidation, as illustrated by loss of nerve force in the brain. Its action here is identical with chloroform, ether, nitrous oxide, or other asphyxiating agent. He considered alcohol to be a food because it evolved nerve force.

Dr. Drysdale did not look upon alcohol as a food. He thought the habit of daily taking alcohol was injurious; he would limit the use of alcohol to that of a drug, and considered that former alcoholic habits alone justified its renewal.

Dr. Sansom considered that alcohol induced contraction and not dilatation of the arterioles, but dilatation might eventually occur.

Mr. Bartlett considered alcohol to be a food. The decomposition of meat and vegetables produced alcohol in their results. He stated that he had been and was engaged in a series of alcoholic experiments from which he hoped to deduce valuable information.

Dr. Symes Thompson stated that alcohol was a subject that had itself been treated intemperately. Alcohol as a dietetic was unnecessary. In exhaustive disease, however, it should be recommended.

Dr. Edmunds stated that alcohol could not be classed as a food, because it acted injuriously on the tissues in its transit. He agreed, on the whole, with Dr. Brunton's conclusions.

Dr. John Brunton drew attention to the marvellous value of alcohol in post-partum hæmorrhage. Two tumblerfuls of brandy might here be drank without intoxication.

The Society then adjourned at 10.30 p.m. until the 3rd January, 1876.

Monday, January 3rd, 1876.

Dr. Routh, President, in the Chair.

Dr. C. Theodore Williams delivered his first Lettsomian Lecture on the Influence of Climate in the Treatment of Pulmonary Consumption.

Monday, January 10th, 1876.

Dr. Routh, President, in the Chair.

The discussion on Dr. Lauder Brunton's paper on the Physiological Action of Alcohol was resumed by

Dr. Milner Fothergill, who thought that alcohol improved digestion, acted as a food, and promoted assimilation. It was a very proper remedy in syncope, and with hot water was advantageous after exposure.

Dr. Drury preferred the term alcoholic fluids to alcohol.

Dr. Lucas considered a stomach unhealthy that did not act without alcohol. If heat is lost by taking alcohol strength also is lost. Alcohol should be administered with much caution.

Dr. Crisp, as a teetotaller, thought alcohol a valuable agent in disease. Previous habits of a patient would influence his treatment. He disputed that the order of the effects of alcohol was cerebral, cerebellar, spinal, and medullary. Alcohol increased mortality 10 per cent.

Dr. Semple held a middle estimation of the value of alcohol. In typhoid fever and delirium tremens it was unnecessary; in post-partum hæmorrhage, on the contrary, it was very valuable.

Dr. Hare considered that, on the whole, the world would have benefited by the absence of alcohol.

Dr. Farquharson drew attention to the adulteration of beer and

its maddening effect upon soldiers. The carouser in the army did not suffer such ill-effects as the quiet steady drinker.

Dr. Sibson always gave alcohol in fevers when the pulse became dicrotic. He quoted Dr. Anstie's opinion, that arterial tension was a most valuable guide clinically for or against its administration. He drew attention to the chronic degenerations induced by alcohol —cirrhosis, arterial degeneration, &c. Alcohol does good in stimulating the kidneys to the extent only of eliminating the poison.

Dr. Leared considered alcohol a valuable agent in obviating the effects of waste.

Dr. Lauder Brunton, in reply, stated how posture facilitated brain power in hæmorrhage. Alcohol stimulated the nerve centres of the vaso-motor system, also forwarded direct influences from medulla oblongata, and so contraction or dilatation of vessels are accounted for. He preferred beefsteak, plus wine, to milk-and-water in promoting rapid recovery. He drew attention to the velvety skin of drunkards due to the deposition of fat; as digestion fails, so thinness results.

Monday, January 17th, 1876.

Dr. Routh, President, in the Chair.

Dr. C. Theodore Williams delivered his second Lettsomian Lecture.

Monday, January 24th, 1876.

Dr. Routh, President, in the Chair.

EXTRAORDINARY CASE OF SKIN DISEASE.

Dr. Crisp brought forward a male patient, aged 29 years, whose face, forehead, scalp, chest, back, abdomen, and upper extremities were covered with a red, dark scaly eruption; there were also a

few spots on the dorsum of the penis and the scrotum. The itching was excessive, depriving the man of sleep. There was no further history of syphilis than that, about six years ago, he had contracted gonorrhœa. He came under Dr. Crisp's care two months previous, and shortly before that time had eaten large quantities of salt ham and bacon. He had been treated with Liq. Arsenicalis (5 drops) daily and a Plummer's pill at night. Dr. Crisp asked the opinion of the Society as to the nature of the disease, and complained of the great need that existed for a large hospital in London for the treatment of skin diseases.

Dr. Tilbury Fox considered this to be a case of psoriasis inveterata, and non-syphilitic.

Dr. Drysdale stated that syphilitic rashes did not itch, and that the scales were much thicker than in syphilis.

Dr. Thin thought it to be syphilitic from the aggregation of crusts on the forehead, discoid patches on skin, muco-watery discharge, two non-suppurating buboes, the infection of his wife, and elbows not affected; three weeks' course of mercury would remove all the scars.

Dr. Fothergill had treated a case similar to this with solution of corr. sublimate in half-drachm doses, and citrine ointment externally. The patient got well.

On Dr. Fox stating that this man was to be admitted into University College Hospital, Dr. Crisp replied that the treatment should prove whether this disease was syphilitic or not.

Dr. Drysdale stated that, on further inquiries, he had changed his opinion on Dr. Crisp's case; the fact of the patient's wife having been infected and two non-suppurating buboes existing over his groins, he (Dr. Drysdale) deemed the rash to be syphilitic.

Mr. William Adams exhibited a case of anchylosis of both elbow-joints, in the extended position, successfully treated by subcutaneous division of the humerus in one, and forcible extension in the other. The anchylosis was due to rheumatism, and the result of the operations, as shown in the man, were highly satisfactory.

Mr. Mac Cormac thought the patient had been exhibited too quickly after the operation. He feared that anchylosis would yet result. A block of bone must be removed to prevent this. He also drew attention to Heron Watson's operation of removing the lower end of the humerus.

Mr. Bryant stated that improvement certainly had resulted, but rheumatic adhesions may be broken down, and yet recur. These elbow cases were not so successful as the division of the neck of the femur.

Dr. Sansom exhibited a form of ether inhaler by Barth, of Duke Street, Bloomsbury.

Dr. Farquharson read a paper

ON OFFICIAL DOSES, WITH SOME REMARKS ON HOMŒOPATHIC TINCTURES.

It is now more than two years since our late lamented colleague, Dr. Anstie, referred, in the pages of the 'Practitioner,' to the very uncertain and misleading directions of our official dosage. The text on which his remarks were founded was a case which made a good deal of sensation at the time, and provoked much varied controversy as to the best mode of obviating the disasters which might at any time arise from a similar combination of circumstances.

A physician in Ramsgate, being in attendance on a severe attack of delirium tremens, prescribed half an ounce of tincture of digitalis, to be repeated if necessary in four hours, but the chemist, observing that the quantity was eight times larger than the maximum dose allowed by the British Pharmacopœia, refused to make up the medicine as ordered.

The patient died, and, in the inquiry which followed, the medical man expressed his belief that digitalis, used according to his instructions, might have arrested the disease, and saved the sufferer's life. And, although the chemist had so far a good line of defence, by appealing to the standard book of official reference in his particular department, he was severely censured by the coroner on the reasonable ground that it was his clear duty to have communicated with the prescriber, and ascertained whether the apparently excessive dose was actually ordered with deliberate intent. Now, although public opinion at that time turned strongly against the man who, by his excess of caution, contributed to so unfortunate a result; and, although it was very properly suggested that an unusual dose of any poisonous substance should always be explained by some well-understood mark or symbol, it is impossible to feel that in this,

as in most cases, there is something to be said on both sides. We must remember that great responsibilities devolve on those who are empowered by law to dispense medicines, that the issues of life and death may depend on the slightest slip or mistake, that they may be at any time held liable for serious consequences. On the other hand, we are all of us liable to error, and in our younger days many of us have, no doubt, inadvertently put on paper some hurried combination of drugs in dangerous quantity, which, if made up as written, might have caused an inconvenient, or even fatal result. It is clear, therefore that the deliberate reading over and consideration of our prescriptions, by skilful and highly practised dispensers, may be of essential service in correcting mistakes, which carelessness or ignorance not unfrequently bring about. On one occasion, when the author ordered Succus Conii in ʒj doses for acute chorea, in a girl of ten, the dispensary prescriber considered it his duty only to give a drachm, and on his next visit pointed out with some concern what he naturally believed to be his mistake. Here no harm was done, for the patient afterwards getting her proper dose was rapidly cured, and the dispenser hailed with satisfaction this addition to his knowledge. One more instance out of others was when, on taking the hospital duty of a friend, the author prescribed 20 minims of belladonna for a child three years old. He would never forget the consternation with which the pharmaceutical official presumed that he had dashed off at least 10 minims too many in the bustle and hurry of out-patient work, and his surprise when he told him that it was his common custom to prescribe much larger doses with benefit.

To begin then with conium, we will find that the authorised dose of the succus is represented as varying from ♏x to ʒj. Now the largest of these quantities is probably without any influence on the human frame, and it is hardly necessary for me to remind you that experiments have shown that we must give from one to four or six ounces before we can expect to derive real benefit from the drug, eight ounces even having been reached without ill effect.

Belladonna, again, is allowed in extract only up to half a grain, which is too small, and to ♏xx of the tincture, which is far within the mark, as I have given from a drachm to ʒiiss to patients suffering from incontinence of urine with marked advantage.

There is also a curious timidity shown in the directions about

quinine, 10 grains of which is held to be the maximum dose. Now, I suppose no fact in medicine is better established than the necessity for administering 20 or 30 grains, or even more, in bad cases of intermittent fever, and the valuable antipyretic properties of the drug only come into play when the dose reached is three or four times in excess of that allowed by the Pharmacopœia.

Then, in the case of aconite two mistakes occur, the minimum quantity of ♏v is too large, for we have all seen the remarkable power of drop doses frequently repeated in checking various inflammatory conditions, and the maximum is also too large, 15 minims being far from a safe prescription in the case of most adults who have over-passed middle life. We have already seen that tincture of digitalis is restricted to ʒss, and we know that the successful treatment of delirium tremens by means of ʒss doses is now one of the commonplaces of medicine; and Dr. Anstie draws special attention to the insufficient quantity, ʒj of tincture of hyoscyamus, allowed, telling us that ʒss is often required in asylum practice.

It must be within the experience of all to have prescribed bromide of potassium in larger doses than 30 grains, and the absurdity of restricting iodide of potassium to 10 grains is almost too patent to require further remark. We all know that some of the most brilliant successes of medicine, and surgery, have been secured by the administration of 20, 30, 40, and even 60 grains.

Coming next to ipecacuanha, we find that, although its properties as an expectorant and emetic are recognised, no mention is made of its specific anti-dysenteric powers; and a dispenser would therefore probably consider it his duty to cut down a prescription in which doses of from ʒss to ʒj of the powdered root were ordered to be taken every two hours.

The tonic dose of sulphate of zinc is put down at from one to two grains, although it is well known that more than double this quantity is often well borne in chorea; and 30 minims is considered the maximum quantity of tincture of ferri perch., although in erysipelas, and acute rheumatism, ʒj is often administered with benefit. The minimum doses of liquor morphiæ, hydrate of strychnia, and tincture of nux vomica, are all placed too high at ♏x, gr. $\frac{1}{30}$, and ♏x, respectively.

The experienced medical man, of course, orders his drugs according to the dictates of his own personally acquired knowledge, and often arrives at practical conclusions, for which we might look in vain

in our text-books; but the beginner feels himself hampered by authority, and the dispenser has his hands tied. On his counter lies the Pharmacopœia for constant reference, and, although not originally endowed with absolutely official powers, it has had that character forced upon it, and must abide the consequences. In any court of justice, in any professional controversy, its decision may at any time be invoked; and we have a right, therefore, to expect that we shall not be misled when its influence is thus brought to bear upon us. Not only should the scale of doses be at once raised, but pains might be taken to indicate the largest quantities which may be, or have been, given with impunity. In short, without converting the Pharmacopœia into a treatise on therapeutics, the attention of those who have so ably superintended its construction might be called to the propriety, and even necessity, for some alterations in the rules which it lays down for the prescribing of drugs.

Before leaving the subject I may lay before you another anomaly connected with dosage. The quantity of tincture of ergot sanctioned by official authority is equivalent to 13½ grains of the powder, whereas that of the powder, or liquid extract, corresponds to 3 grains. Thirty minims of tincture of digitalis equals three grains of the dried leaves, whereas the ordinary dose of the infusion is only equivalent in value to 1½ grain.

Aloes varies in its different preparations from three to eight grains; of tincture of belladonna, ℥xxx equals gr. j of leaf, whereas gr. j of the extract corresponds to ʒj of the tincture, whilst nux vomica supplies a still more glaring example, seeing that ℥xx of the tincture corresponds to two grains of the powdered seeds, whereas of the extract two grains equals ʒss. It is difficult to see that these curious discrepancies have been made with any deliberate intention, and the inference is therefore fair that they have merely crept in from some carelessness or want of method on the part of the constructors of our national Pharmacopœia.

That many of the modern homœopathic preparations are of dangerous strength has long been generally known, but to Dr. George Johnson is undoubtedly due the credit of bringing the matter home to us more directly. He brings forward five cases, occurring in his own practice, and in that of others, in which unpleasant, and even dangerous symptoms, consisting of epileptiform convulsions, violent pain in the head and spine, nausea, stupor, &c., were caused by doses of the concentrated homœopathic solution

of camphor, ranging from eight 2-minim doses up to twenty 25-minims, and a teaspoonful. In some of these entire recovery only very slowly took place, and various distressing nervous sensations were experienced in the case of a young lady for fully eight months, after a single dose of 25 drops.

Feeling desirous of obtaining some approximate idea of the strength of the strong or mother homœopathic tinctures, I procured some of the tinct. aconiti, buying it over the counter at a chemist's shop without any difficulty, and made the following experiments:— At six minutes to three o'clock on Wednesday, January 19th, I injected five minims beneath the skin of a full-grown rabbit, and, no effect being produced, in five minutes I injected 15 minims more. In three minutes, violent convulsive movements of the diaphragm set in, with attempts at vomiting, and a peculiar fighting motion of the fore-paws, as though trying to remove some obstruction about the mouth. A paralysed condition of the hind legs followed, and death ensued, after a paroxysm of general convulsions, in exactly five minutes after the injection was performed. Ten minims proved fatal to a rather smaller animal in twenty-five minutes, the symptoms following exactly the same sequence, and regularity. I find that 90 drops, dropped from the ordinary homœopathic drachm tincture bottle, correspond to 60 minims; and we therefore see that 15 drops is sufficient to kill a rabbit.

Coming now to tincture of belladonna, I have found on personal experiment that ♏x of the homœopathic mother tincture taken at night caused some dryness of the throat, with disturbed sleep, and much dreaming; and three more doses, at intervals throughout the next day, were sufficient to keep up the same parched feeling about the mouth and throat, with an uncomfortable sensation of dryness, and irritation, over the skin generally.

This is, therefore, evidently much stronger than our own tincture, which may usually be given in doses of from 15 to 20 minims, without the induction of physiological symptoms until the drug has been persevered with for some time.

The strong tinctures, which are freely vended to all comers, have luckily not yet been taken into very general domestic use, or one might anticipate a long series of tragical events, before which even Dr. Johnson's interesting cases would hide their diminished heads. The dangers to be anticipated would seem to me to be fourfold:

1. The free purchasing of these poisons with homicidal, or suicidal intent.

2. The rash confidence engendered in the minds of old-fashioned homœopathists regarding the weakness of their drugs, and the confidence with which they may be used. A mistake of this sort being made with aconite would not be likely to occur to the same patient a second time.

3. The great probability of the mother tincture being mistaken for some of the dilutions, and recommended, right and left, in the usual free-and-easy way by amateurs. This might also be serious.

4. And, finally, the possibility of the strong homœopathic tincture being mistaken for, and used instead of, our weaker preparations.

Dr. Crisp stated that two drachms of antimonial powder and half-ounce doses of tinct. digitalis had been given. He thought it questionable, if a large dose could be given, whether it should be administered. The prescriber should insert a foot-note where unusual doses were ordered.

Dr. Edmunds suggested that by taking the atomic weights of chemicals we might arrive at normal standard solutions.

Dr. Brunton exposed the illegibility of prescribers' writing. Oft-repeated doses seemed to be more beneficial than large doses. He exhibited a homœopathic pharmacopœia, and stated how ridiculous it was to permit homœopathic druggists to prescribe with so much freedom.

Dr. Drysdale considered that chemists were quite justified in returning illegible prescriptions.

Dr. Thin stated that the physiological action of drugs must be known before their doses can be given accurately; the elimination of a drug had much to do with its effect.

Monday, January 31*st*, 1876.

Dr. Routh, President, in the Chair.

Dr. C. Theodore Williams delivered his third, and last Lettsomian Lecture.

Dr. Sansom proposed a vote of thanks to the author. The Society had always encouraged practical work, such as related to every-day practice, and these Lectures had been of considerable service in promoting this. He highly approved of Dr. Williams' selection of the subject of the climatic treatment of pulmonary consumption, and suggested the idea of a hospital ship for phthisis. Lectures were of great advantage, as combining theoretical with practical knowledge.

Mr. William Adams seconded the vote of thanks, and remarked that a safe and reliable basis in consulting practice might be founded on these lectures.

Dr. Williams expressed his thanks, and said that much of the real value of the lectures he had just concluded was due to his father's store of knowledge.

Monday, February 7th, 1876.

Dr. Routh, President, in the Chair.

Dr. F. de Havilland Hall related a case of

TRANSPOSITION OF THE VISCERA.

"H. B—, æt. 31, a potman, attended January, 1876, as an out-patient under my care at the Westminster Hospital, complaining of rheumatic pains. He stated that he had always enjoyed good health with the exception that he was subject to rheumatism. Sixteen years ago he was laid up with rheumatic fever for four months. Eight years ago he had a second attack for which he was admitted into Guy's Hospital. The last attack was six months ago, he was ill for three months, and he has not been quite free from pains since. No history could be obtained of any lung affection. On proceeding to examine the heart I was considerably puzzled for the moment, as I failed to detect it in the usual situation, and on my remarking to the patient that his heart did not beat in the ordinary position, he replied that Dr. Habershon had detected a malposition of the viscera while he was an in-patient at Guy's Hospital, and the patient added that, as long as he could remember, the heart had always beat in the same place. On making the man lie down the

apex was found to beat in the fifth interspace on the right side, half an inch to the inner side of the right nipple, beat somewhat diffused, and the area of cardiac dulness more than normal. Systolic murmur at apex, audible in right axilla, and faintly so behind. There was perfect resonance in the right hypochondrium, but, on the left side there was dulness in the axillary line, extending up from the costal arch to the sixth rib. The right testicle was lower than the left.

"On going over this case carefully I came to the conclusion that the alteration in the situation of the apex beat must be due to a congenital malposition of the viscera; in the first place the patient himself was confident that his heart had always beat where I detected it; secondly, his chest was well formed, and I could not elicit any history of previous illness, sufficient to account for so great a displacement of the heart; thirdly, there was the absence of the ordinary area of hepatic dulness, whereas there was dulness in the left hypochondrium to the extent which usually attains on the right side; and lastly, as a minor point, the right testicle was lower than left, contrary to what is usually the case. This is the first patient in whom I have detected a transposition during life; but, some years ago, I saw in the post-mortem room at St. Bartholomew's Hospital a body in which all the viscera were completely transposed; this fact was not recognised during life, as the man was brought in when moribund, and died soon after admission."

The man who was the subject of this communication was then shown to the Fellows of the Society.

Dr. Williams stated that it was not infrequent in dogs to find the heart tilted to the right side. He asked if any inflammatory chest affection had existed.

Dr. Lee considered that the transposition of the liver in this case was more curious than that of the heart.

Dr. Fothergill did not consider these cases rare.

Dr. Robert J. Lee exhibited a steam inhalation apparatus.

Mr. Brown considered dry air to be needed in respiratory complaints, and Turkish baths valuable on this account.

Mr. Napier eulogised the apparatus, the lungs not being called on to exert themselves. Practically it answered well.

Dr. Drysdale stated that the so-called casellas anenometer was invented by Mr. Lowne, of the Middlesex Hospital.

Dr. WILLIAMS preferred a pint jug for inhalation purposes. Hot damp air is too enervating for phthisis, but suits bronchitic patients. Brompton Hospital is ventilated by means of a steam coil.

Mr. DAVY thought Dr. Lee's machine very applicable for surgical dressings. The steam jet was considered the very life of an engine; so Dr. Lee's steam jet would perhaps prove the life of inhalation.

Mr. RICHARD DAVY narrated two cases of reamputation:

CASE 1.—The subject of an amputation through the ankle-joint fell, and broke the shaft of her tibia. Fibrous union resulted. The fibula became so bent that the girl could not walk. Mr. Davy reamputated through the fibrous union, and exhibited the patient wearing an artificial leg.

CASE 2.—Boy with conical stump of leg, which had been removed for diseased ankle-joint. Mr. Davy removed the terminal inch of tibia, and fibula, by two side apertures made in the leg. The very fine watch-spring saw was shown to the Fellows.

Mr. WM. ADAMS stated that he had only seen two cases of ununited fracture in children. He wished Mr. Davy had reamputated higher up in order to have gained a valuable pathological specimen.

Mr. DAVY stated that Case 1 was not rickety, and that both the cases illustrated well how mechanical relief might be gained by surgically inflicting but little injury.

Monday, February 14th, 1876.

DR. ROUTH, President, in the Chair.

In a communication on epilepsy Dr. Boyd gives an analysis of eighteen (twelve males, and six females) fatal cases, and post-mortem examinations made in the St. Marylebone Infirmary. Also, of the termination of 310 cases of epilepsy, 181 males, and 129 females, admitted to the County Somerset Lunatic Asylum.

With epileptics under puberty in the Somerset Asylum were also idiots. Convulsions, epilepsy, and idiocy appear to form a natural order, a distinct class in themselves; whilst insanity in its various forms, which often alternate in the same individual, form a second and distinct class of the functional disorders of the brain, and

recent inquiries lead to the conclusion that arrangements are required for the treatment of them separately. The practical reasons adduced for the separation of these classes are, that the association of epileptics with others in asylums is injurious, and that the younger idiots are capable of instruction, and ought to be removed to institutions established for that purpose.

The symptoms of epilepsy were given.

With a view of fixing the treatment, the commonly adopted division of epilepsy is into "idiopathic" which arises in the brain or spinal cord; and "sympathetic" where the exciting cause is in some remote organ. These terms are synonymous with "centric" and "eccentric," employed by Dr. Marshall Hall. Sauvages and Sagur make as many varieties as there are principal exciting causes. A similar proposal with respect to insanity has been made by the late Dr. Skae, of Edinburgh, in his classifications of mental diseases.

Epilepsy is complicated with various defects or disorders of the mind:—1st. Epileptic idiots; 2nd. Epileptic imbeciles or demented; 3rd. Epileptic maniacs, who, without obvious disorder of the mind, when epileptic fits are coming on, become dangerous and perpetrate the most atrocious acts. Mr. Montford's theory on the identity of nervous influence with the electric, when it explodes in an epileptic seizure or something analogous, has latterly been brought forward.

Fright has induced convulsions, which have been repeated till they terminated in a most deplorable case of epilepsy. The symptoms, even though so severe as to cause death suddenly, often leave no perceptible post-mortem changes. Changes are often found in the skull, in the membranes of the brain and spinal cord, and in the structure of the nervous centres, in cases of epilepsy; but the same changes are found in the bodies of those who have never been subject to epilepsy. Such are thickening and opacity of the membranes, with an increased quantity of fluid in the ventricles which the author believes to be a natural decay, either premature, or when the brain becomes diminished in size, the effects of old age. In epileptics there is sometimes found a partial absorption or diminution in the size of the brain, and, on the other hand, it is sometimes found enlarged.

In a young man, æt. 23, affected with fits from childhood, who died after a rapid succession of fits, the encephalon appeared to be too large for the skull, and weighed 54 oz. Enlargement of the brain in cases of sudden death was first observed at the St. Maryle-

bone Infirmary by Dr. Sims. A deficiency in one cerebral hemisphere, with hemiplegia of the opposite side, and arrest of development in the limbs, in epileptics, was first observed by the author at the St. Marylebone Infirmary in 1842 ; a notice of these cases, with a drawing of one from the brain, in the Museum of the Royal College of Physicians, will be found in the thirty-ninth volume of the 'Transactions of the Royal Medical and Chirurgical Society of London.'

In 45 out of 89 male epileptics there was an inequality in weight of from $\frac{1}{4}$ to $6\frac{1}{2}$ oz. between the cerebral hemispheres; also in 35 out of 61 females, an inequality of from $\frac{1}{4}$ to $2\frac{1}{2}$ ounces.

The youngest case of epilepsy recorded in the micrological register of the St. Marylebone Infirmary was that of a male infant, of one month. When a fortnight old the baby had fits similar to those of its mother, who had been for some years epileptic. Brain appeared natural, $13\frac{3}{4}$ oz. Chest, an ulcer between the costal cartilage, through the mediastinum to the edge of funis.

During upwards of twenty years $9\frac{1}{2}$ per cent. of the patients admitted to the Somerset County Asylum were epileptics, and, contrary to the experience of Esquirol, who states the number of females to exceed the males by one third, the males exceeded the females by nearly a sixth. The greater size of the head in the male fœtus, and consequently its greater liability to injury in parturition, renders the male more liable than the female to convulsive diseases in early life. Esquirol considers epilepsy to be contagious ; which is supported by facts relative to the contagiousness of convulsions, so fully described in Hecker's 'Epidemics of the Middle Ages.' The necessity of separating epileptics from the insane is strongly supported by such evidence as this, also, by at least three instances of persons, not known previously as epileptics, having been seized with epileptic fits after kindly giving their assistance to patients in their attacks in the Somerset Asylum.

The terminations of the 310 cases of epilepsy, 181 males and 129 females, were :

Recovered for the time, 6 males, 2 females.

Relieved, 10 males, 11 females.

Not improved, 17 males, 11 females ; transferred to asylums, and friends.

Died, 103 males, or 57 per cent. ; 65 females, or 50 per cent.

Remaining in asylum, 45 males, or $24\frac{3}{4}$ per cent. ; 40 females, or 31 per cent.

In two of the six recoveries in the males the fits were attributable to excessive drunkenness—not an uncommon cause in the experience of military surgeons.

In the 21 cases relieved age does not appear to have influenced the result. The pulse on admission, in the majority of cases in both sexes, was above the natural standard. The causes assigned were, in three males drunkenness, in two injuries to the head; in two males phthisis; and three females, bad health; two males and two females inherited the disease; in one female it came on during pregnancy, being the second attack from the same cause; in one female from fright; in one female it was combined with hysteria; and in one with syncope; in one male, and two females, no cause was assigned. Two of the females had lost several infants in convulsions; one of them had lost four out of eight from this cause.

Post-mortem examinations were made in 155 of the 168 fatal cases, 94 in males and 61 in females. The following is a summary of the results in each sex at decennial periods of life.

Age.—Under twenty years there were eight males and one female, all of whom were congenital idiots; the period from 20 to 30 included the greatest number of males, 31, *i. e.* nearly a third, and only 12 females; from 30 to 40 years there were 20 males and 23 females, being the greatest number of the latter sex, and above a third of the whole number; from 40 to 50 the number fell off to 13 males and 14 females; from 50 to 60 there were nine males and seven females; from 60 to 70 six males and three females; and from 70 years upwards seven males and one female. It thence appears that epilepsy is most prevalent at an early age, and also that the greatest mortality is at an earlier age in males than in females.

The assigned cause of death was given at each decennial period of life. Epilepsy if combined with insanity is considered incurable, and the treatment of it in a great measure empirical. Attention to diet and regimen is of importance. In the young, especially, the bromide of potassium has been given with relief. Aperients have also been found to alleviate the severity of the fits, the inhalation of nitrate of amyl has latterly been used, and has a decided influence in sometimes arresting a fit. The treatment employed should be regulated by the symptoms in each individual.

The deaths from epilepsy have been very nearly double those from insanity.

Dr. Edmunds expressed surprise that Dr. Boyd had not mentioned

syphilis in relation to the etiology of epilepsy. He had seen at the autopsies of patients, who had during life displayed convulsive movements of one arm, syphilitic deposits in the membranes covering the opposite part of the hemispheres. With regard to treatment, he thought that abstinence from flesh food, and almost a strictly vegetarian diet, lessened the frequency and force of the attacks.

Dr. Drysdale had seen several hundred cases, of all of which he had kept notes, and some points had struck him as of importance; *first*, the number of cases in which fright had been the exciting cause. This was especially applicable to females, and he thought that a fourth of the whole number had arisen from this cause. He had seen very few cases of syphilis associated with epilepsy.

Dr. Gibbons confirmed the last speaker's views as to fright giving rise to the first attack. He quoted the case of a patient who is always free from attacks when pregnant, but only at such times. He had found benefit from phosphorus, especially in young persons, and believed that a Turkish bath would often suspend the attacks for at least a month.

Dr. Rogers had seen two patients in whom pregnancy completely arrested the disease, but in whom the fits returned soon after delivery. From this he considered there could not be much structural change in the brain tissues.

Dr. de Havilland Hall was of opinion that nitrate of silver was very useful in the treatment. In one case he had seen marked benefit therefrom. He thought that moral and intellectual treatment should never be neglected, amusement and a certain amount of study preventing the patient from dwelling on the malady.

Dr. Theodore Williams wondered what part the circulation plays in epilepsy. He believed the action of bromide of potassium to be upon the arteries, and he knew a case, in which heart disease appeared to be the cause of the epilepsy, where this drug overcame both the palpitation and the fits.

Mr. Harris quoted a case in which a sister had taken the disease from attending to a brother suffering from it.

The President thought that the reason why the attacks were arrested during pregnancy was that at such time ovarian irritation was allayed, the fits returning as soon as the ovaries again commenced work. He believed nitrate of amyl to be of great benefit in some cases.

Dr. Boyd replied.

Monday, February 21st, 1876.

Dr. Routh, President, in the Chair.

Mr. Francis Mason exhibited a girl, aged 14, on whose left breast was a cicatrix an inch and a quarter in diameter. Mr. Mason observed that the case illustrated in a remarkable manner the fact that cicatrices increase not only in proportion to the growth of the body, but that if situated on a part such as the breast they grow in proportion to the development of the organ on which they are placed. When three months old the girl had been operated on for nævus, and the scar that remained after the operation was about the size of a sixpence. Six months ago she reached the period of puberty, and as the breast became gradually developed, so the size of the cicatrix became proportionately larger. The cicatrix caused her no uneasiness.

Mr. W. Adams stated that cicatrices grow *pari passu* with the neighbourhood over which they are situated.

Mr. Gant thought that cicatrices stretched. This growth of scar should not enter too far in surgical consideration, as the subcutaneous operation is alone applicable in certain cases.

Mr. Gant brought forward

A CASE OF LITHOTRITY IN A FEMALE.

L. W—, aged 27, married one year, never pregnant; menstruation always regular. Three months before marriage she first felt pains in her bladder, which were aggravated by any movement in walking or riding. For the last three months she has noticed blood in her urine. On admission into the Royal Free Hospital, having these symptoms, Mr. Gant sounded the bladder, and at once struck a stone in the fundus, which seemed to have a rough surface. As the patient looked very pale and weak, and the bladder was unusually sensitive, the urine was examined and found to be loaded with albumen, which may have been partly due to the blood discharged on the slightest movement. The pain was now

acute and of a darting character, unlike that occasioned by an ordinary calculus, although it was always worse after passing water. On sounding again the stone lay in exactly the same position, and could not be moved by any fair use of the instrument. The quantity of albumen became much reduced in the course of a few days' rest. Then, putting the patient under chloroform, and placing her in the position for lithotomy, he gradually dilated the urethra by a three-bladed dilator worked by a screw until he could almost pass his finger into the bladder. About four ounces of water were injected, and a long, slender, urethral stone was readily seized; it could not be extracted, being evidently too large to pass through the dilated urethra. He then introduced a lithotrite and crushed the stone very easily, but the male blade could not be driven entirely to the end of the female blade. A second application of the lithotrite failed in like manner. He thought there might be an unusually hard nucleus between the blades; but it was a sensation he had never before known, and he made no further attempt to crush this body, nor to extract it, or any fragment of the stone. On the following day the urethra was not swollen, and fragments began to come away through the passage, the urine remaining bloody. In two days a hairpin, bent at a right angle, was voided, followed by more *débris* of the calculus, which encrusted the pin as a nucleus. The patient then stated that previous to marriage she had *swallowed* a hairpin. Of course, however, this was one of those strange instances in which a foreign body had to be introduced up the urethra to gratify some morbid feeling. In this history of a hairpin the oddest event was not its unnatural entry into the bladder, nor the disturbance referable to its residence there, but its expulsion from the bladder by a natural effort, especially when apparently impassable through a dilated urethra. This case also exhibits an occasional, and unforeseen difficulty, which may be met with in lithotrity. No more *débris* came away by injecting. No symptom of stone, nor incontinence.

The PRESIDENT narrated a case of vesico-vaginal fistula operated on. On the silver sutures a stone formed, the urethra was dilated by a three-bladed instrument, the bladder was opened, the foreign body removed, and the patient recovered.

Mr. NAPIER thought that the hairpin might have been rusted by the urine, and so broken off and passed.

Dr. MILNER FOTHERGILL narrated cases of a catheter and an

ivory needle-case found in the female bladder. The urethral pudic nerve is the only nerve left for irritation after clitoridectomy.

Mr. Davy considered the finger a most intelligent probe, and the finger and thumb the most educated pair of forceps. He drew Mr. Gant's attention to Mr. Bryant's urethral dilator, which combined not only a speculum, but also a channel for removal of a foreign body.

Dr. F. de Havilland Hall showed an

ABDOMINAL TUMOUR GROWING FROM THE LUMBAR VERTEBRÆ, AND SIMULATING AN ENLARGEMENT OF THE LIVER.

The patient, a female, æt 23, was admitted into the Westminster Hospital under the care of Dr. Sturges, on October 19th, and died from exhaustion on November 13th.

Previous to her admission she had been ill for about two months, vomiting after taking food, and loss of flesh, being the most prominent symptoms. On making a physical examination of the abdomen a tumour was discovered, about the size of the head of a child a year old; it was firm, immovable, somewhat tender, and not to be separated from the liver dulness; it was situated rather more to the right than to the left side. Hepatic dulness not increased upwards. There was no jaundice, and the spleen was not enlarged. Urine albuminous.

Post-mortem examination, made thirty hours after death.—On opening the abdominal cavity a huge mass of a somewhat rounded form, and about the size of a child's head, was found occupying the abdomen; it was intimately adherent to the under surface of the liver, and to the abdominal parietes on the right side; to the left there was a free border. *In sitû* it appeared to be entirely composed of fat, as the superficial part was almost all adipose tissue, but, on removing it, the case was found to be intimately attached to the lumbar vertebræ, and here the tumour was of a fibro-cartilaginous nature. On making a section through it a coil of the small intestine was found imbedded in the tumour, and pus exuded along the course of the gut, which was contracted. The tumour extended to the right lumbar region, and, in the spot where the kidney ought to have been, there was in the tumour an appearance of a cystic formation, which was evidently the contracted kidney; on making an

incision into this part pus exuded. Left kidney, cortical substance rather narrow. Liver not increased in size, fatty. Spleen not enlarged.

During life the tumour was diagnosticated as an enlargement of the liver, and from its intimate connection with the under surface of that organ it is difficult to see how this mistake could have been avoided. From the woman's cachectic appearance it was assumed to be malignant, and, from the constant sickness and retching after taking food, it was believed that the growth had extended to the pyloric orifice of the stomach. Owing to a mishap the microscopical character of the tumour was not forthcoming, but, from its general appearance, and rapidity of growth, there can be little doubt that it was malignant.

Dr. Routh mentioned that suddenly growing tumours are due to bursting of a Graafian vesicle. They attach themselves to the kidney, and take on similar growth to it.

Dr. Wiltshire stated that this growth was behind the peritoneum. He looked upon it as fibro-scirrhous.

Mr. Henry Smith showed an os calcis that he had excised for partial necrosis. The interest of the case consisted in the fact that removal of the inside of the bone had been practised on a previous occasion for necrosis, but the sinuses did not close, and removal of the entire bone was performed. The speculum showed in the interior a portion of necrosed bone about the size of a walnut, nearly loose.

Mr. Gant considered scooping of the tarsal bones advantageous.

Mr. Royes Bell believed that in time the bone would have exfoliated.

Mr. Wm. Adams thought partial operations failed. Necrosis, and not caries, was a pathological law observed by os calcis.

Mr. Davy condemned the plunging operations done in the dark by the gouge. Esmarch's apparatus facilitated the removal of tarsal bones. He had removed six cuboid bones successfully. He considered Mr. Smith's practice here followed to be the best.

Monday, February 28th, 1876.

Dr. Routh, President, in the Chair.[1]

Dr. Brunton showed two boys who had been affected with

ACUTE HYDROCEPHALUS,

as samples of many that he had cured by the administration of bromide of potassium. The elder boy had now been well for six years, was active, intelligent, and a good scholar. When first called to treat him Dr. Brunton found him listless, and partially imbecile, in such a condition that he would eat anything presented to him, and did not know the difference between an orange and a raw potato; his head was very much distended, and at the age of three and a half years both anterior and posterior fontanelles were widely patent, and distended with fluid. Acute symptoms supervened, and for some days he was insensible; bromide of potassium, in two-grain doses, was administered every hour with marked effect, a rapid recovery took place, tonics were afterwards administered, and he is now well.

The other boy took an acute attack at the age of thirteen months. He was insensible for a fortnight, and lay on his mother's lap nearly the whole time. Bromide of potassium was given, one grain at first, and afterwards two grains every hour, and, diligently persevered in, produced a result similar to the first case.

These, and many other cases were treated by this plan, because Dr. Brunton had found the method laid down in books so unsatisfactory that he looked about for something new; and seeing that in acute hydrocephalus there is much increase of vascularity, greater amount of blood supply, and consequent effusion, and at the same time diminished power of absorption produced by the fluid pressure, he thought if the blood supply could be reduced, the effusion would be arrested, and absorption of the products of effusion would take place. Now, such a remedy Dr. Brunton believed he had in bromide of potassium, because it was well known to produce sleep by diminishing the supply of blood in the brain, and on this account he employed it, and with a success that, to him, was far

superior to any other method of treatment. He did not say that every case he treated got well, but many that in other circumstances he would have considered hopeless did well, and are now alive.

Dr. Day inquired for details of the symptoms. He described a chronic basilar meningitis. These cases recover, while the tubercular ones die. He considered mercury and bromide of potassium valuable remedies for such diseases, but preferred the former.

Dr. de Havilland Hall inquired what Dr. Brunton meant by acute hydrocephalus. Tubercular cases were fatal.

Dr. Lee described chronic hydrocephalus as an effusion of serum into the cavities of the brain, rendered possible by rickety bones and yielding walls. He recommended ice, cod-liver oil, and rest.

The President accredited more to hygiene than drugs in the treatment of hydrocephalus; even paralytic cases had recovered under careful treatment. Counter-irritation and nitrite of amyl were mentioned as useful agents.

Dr. Edmunds advocated perchloride of mercury and sedatives to the alimentary canal. Rolling of the head backwards, fixed pupil, and paralysis, betoken death. Effusion of serum in the ventricles had not been noticed so frequently as cheesy matter at the base. In œdema of the brain he considered that the calibre of the vessels was mechanically lessened.

CASE OF INDURATION OF THE CERVIX UTERI.

Dr. Heywood Smith, after some prefatory remarks on the importance of cases of induration of the cervix uteri, especially with regard to the question of their malignancy or benignity, narrated the case of A. B—, æt. 35, married fourteen years, who became an out-patient at the Hospital for Women, March 15th, 1875. She had been pregnant twelve times, resulting in seven labours at term, and five abortions, the last an abortion two and a half years ago. The catamenia commenced æt. 15½. She complained of falling of the womb, and bleeding at the intercatamenial periods. A medical man had "thought" she had ulceration of the womb.

Dr. Heywood Smith here made some remarks on the disadvantage of medical men hazarding an opinion on a case without physical examination, as being as much to be deprecated as if an opinion of bronchitis were given, without an examination of the

chest. He took occasion to remark that it would tend to lessen the ground of complaint of medical men in general practice, that hospital physicians and surgeons took cases from them, if such medical men could obtain for their poor patients the same advantage they gave their richer patients, viz. a consultation. He stated that he believed that medical officers of hospitals would be glad to see patients so referred to them at their respective hospitals, and to transmit to their ordinary medical attendants a written opinion of the case, and if required suggestions for treatment. In this way he contended medical men would retain their patients, and the labour of the out-patient departments of hospitals would be materially lessened.

In A. B—'s case a vaginal examination revealed the anterior lip of the cervix greatly hypertrophied, hard, its surface granular and bleeding. She was admitted as in-patient March 29th, 1875. There was no history of hereditary disease. The uterus was movable; the mass of the cervix filled the upper part of the vagina, and the uterine sound passed four inches. On two separate occasions portions of the disease were removed with the écraseur, and the subsequent treatment consisted in freely destroying the tissue with Potassa Caustica.

Dr. Heywood Smith much preferred the use of the strong caustic to any milder form, as there was no temptation to leave it packed against the cervix, which might lead to extensive destruction of the vagina. The result of the treatment was that the cervix had not only been removed, but a deep excavasion of about one and a half inch deep had been made into the diseased tissue of the uterus. He remarked further on the progress of the case, that the uterus still continued movable, which would probably not have been the case if the disease had been of a malignant character, and he inclined to the opinion that the case was one of areolar hyperplasia.

Since the above notes were made the patient has greatly improved in health, she has little or no pain, and the cavity is fast closing up by the contraction of the uterine tissue.

Dr. Lee considered the whole of uterine pathology quite erroneous. The os uteri seemed to have a remarkable attraction for obstetricians. For his part he failed to see why uterine pathology differed from surgical pathology, and he ventured to think that the practice pursued was not calculated to produce the best results.

Mr. Henry Smith narrated briefly a case of imminent death from chloroform, the fatal result having been prevented by inversion of the body. He related also a case of death from chloroform in his own practice, where he had omitted to avail himself of Nélaton's plan of lowering the head and raising the heels.

Monday, March 6th, 1876.

Dr. Routh, President, in the Chair.

The ballot for the election of officers and Council for the ensuing year was opened at 7.30.

The President read an invitation from the President of the International Medical Congress in Philadelphia, requesting the appointment of delegates to represent the Society on the occasion.

The Honorary Secretary then read the Report of the Council for the past session.

The ballot was closed at 8.30, and Drs. Bloxam, Haward Knox, and Williams, appointed scrutineers.

The Honorary Librarian then read his Annual Report.

The subject for the Fothergillian essay for March, 1878, was announced, being

THE ANTAGONISTIC ACTION OF THERAPEUTIC AGENTS.

Dr. John Brunton then read a paper entitled

AN OLD REMEDY REVIVED—THE THERAPEUTIC USES OF PULSATILLA NIGRICANS.

After stating that the subject of his paper was solely suggested by the perusal of Baron Störck's monograph on Pulsatilla Nigricans, he proceeded to give a history of the plant, showing that it was not indigenous, but merely a garden plant used for ornamental purposes in England, and that it grew wild in Germany, and was very like our wild Anemone Pulsatilla, which grows abundantly in dry chalky situations in England. After mentioning that several of our standard herbal drugs, such as Hyoscyamus, Conium, and Col-

chicum, were credited by Professor Christison for their introduction into medicine to Baron Störck, Dr. Brunton proceeded to account for the almost total disuse into which Pulsatilla Nigricans had fallen for upwards of a hundred years in this country. This he said was due to adulteration, or rather the substitution of Anemone Pulsatilla for Pulsatilla Nigricans, the former according to Störck having scarcely any medicinal properties at all, whilst the latter was very powerful, while Woodville says that the two plants so resemble one another that the former might be easily taken for a substitute for the latter. Baron Störck was just as particular in seeing that the true plant was used in this case as in the case of aconite. It was of no use to practise with the wrong drug. Dr. Brunton explained the difference betwixt the two plants by drawings, and stated the difficulty he had in obtaining the true herb. Mr. Foster, chemist, of Houndsditch, failing to obtain it in London, procured a supply from Germany, which, when examined, and tested, exactly corresponded with Störck's plant in physical and medicinal properties.

From this he had tincture made which he had used extensively for the past two years in the treatment of the acute affections of mucous membranes, especially those of a catarrhal nature. He mentioned that it was depressant to the circulation and respiration if pushed, caused vomiting, purging, and even convulsions, while full doses produced vertigo and fulness of the head. He had not himself experimented on the lower animals with it, but had accepted Baron Störck's observations, and results, with a similar amount of faith to what he had given to his observations on aconite. Though others had totally failed with pulsatilla he thought that was due to the use of the substitute, and not the true herb. A crystalline alkaloid called anemonine was supposed to be the active principle, but being insoluble in cold water and alcohol, and but sparingly soluble in boiling water and boiling alcohol, and being tasteless, and only acrid to taste when in fusion, Dr. Brunton thought that in this separate form it could not be the active property, because the tincture and extract of the plant both made with water and alcohol were active enough ; hence, on consulting ' Christison on Poisons ' he found that in corroboration of his views the active part was a volatile oil, which held anemonine in combination with anemonic acid amongst other things; also, as anemonine could be got from the roots of many of the Ranunculaceæ, the parts of Pulsatilla

Nigricans used in medicine were the stem, leaves, and flowers, not the root. After relating a series of acute nasal, bronchial, vaginal and vesical catarrh, amenorrhœa, and acute ophthalmia, so rapidly and successfully cured by pulsatilla as to be, so to say, cut short, he mentioned that he had used it in dyspepsia, and other diseases of the mucous membranes. His experience was limited to about 100 cases, and he was of opinion that we had a drug, though long lost to use, if properly and carefully prepared from the true plant, which would yet take a forward place in the treatment of acute, as well as chronic affections of the mucous membranes.

Dr. Jagielski stated that the drug was used in Silesia as a homœopathic remedy. He had gathered the plant there in its wild state.

Dr. de Havilland Hall asked what the full dose is, and how it acts poisonously?

Dr. Thorowgood remarked how opinions about drugs vary. Taraxacum, considered by some to be useless, is praised by Indian physicians. One instance of the use of pulsatilla for catarrhal asthma was negative.

Dr. Heywood Smith advocated the use of pulsatilla in amenorrhœa.

Dr. Milner Fothergill considered that the action of this drug on the mucous membranes was very indefinite. He suggested that experiments should be made with it on living animals.

Dr. Routh stated that in Dr. Philip's work especial attention is given to this drug. He used it now invariably in amenorrhœa, thirty drops three times a day. Headache and vertigo are produced by one-drachm doses. He considered that cases of vaginal catarrh got well in three days, whether they had pulsatilla or not.

Dr. Bloxam asked if the drug had any influence on the pupil.

Dr. Brunton replied; the whole herb excepting the root is used locally, it acts as an anodyne, and has not any specific action on the pupil.

The result of the ballot was then declared.

Wednesday, March 8th, 1876.

The dinner celebrating the 103rd anniversary of the Society was held at the Criterion Restaurant, Piccadilly Circus.

Dr. Routh, President, in the Chair.

Upwards of seventy Fellows and guests attended.

Monday, March 13th, 1876.

William Adams, F.R.C.S., President, in the Chair.

The President delivered an address on

SUBCUTANEOUS SURGERY,

A subject which he selected partly in consequence of the forthcoming celebration in Hanover of the fiftieth anniversary of the admission of Stromeyer to the Doctorate of Gottingen, an event in which many English surgeons had decided to participate by offering an address to Stromeyer on the occasion of this jubilee, and requesting him to sit for his bust to be executed in marble to be deposited in the Royal College of Surgeons of England.

Mr. Adams then spoke of Stromeyer as the founder of subcutaneous surgery, by the operation of subcutaneous tenotomy, which he perfected and performed in the year 1831, and also adverted to the distinguished position he had held for many years as a military surgeon, acting as surgeon in chief of the Schleswig Holstein army in the campaigns of 1848 and 1851, and also as surgeon in chief with the 3rd Army Corps, commanded by the Crown Prince of Prussia, during the recent Franco-German war.

Stromeyer's objections to the operation of trephining in cases of depressed fracture of the skull were mentioned.

Mr. Adams then alluded to the circumstance of subcutaneous tenotomy having been introduced into England by Dr. Little, who had been operated upon by Stromeyer in the year 1836, and who, himself, performed the operation in London in the year 1837. But

Mr. Whipple of Plymouth had divided the Achilles tendon subcutaneously in May, 1836, and was not at the time aware of its having been performed on the Continent.

The law of subcutaneous surgery, Mr. Adams observed, was first enunciated by Hunter in his 'Treatise on the Blood, Inflammation and Gunshot Wounds' published in the year 1794, and there can be no doubt that he first recognised as a great fundamental principle in reference to the healing of injuries, the difference between those two forms of injuries, of which one is subcutaneous and the other open to the air. Hunter observes, "The injuries of the first division, in which the parts do not communicate externally, seldom inflame, while those of the second commonly both inflame and suppurate." Although Hunter did not apply this law to surgical practice, he divided tendons subcutaneously by introducing a couching needle under the skin at some distance from the tendons, in his experiments on animals to ascertain the nature of the process by which divided tendons are reunited.

The subcutaneous law in its practical significance was more fully recognised by M. Jules Guerin in the year 1841, and to him we are indebted for its development and surgical application.

A large number of surgical operations performed on the subcutaneous principle, and depending for their safety on the subcutaneous law were then enumerated, Mr. Adams observing that the list had been, of late years, still further enlarged by various operations for anchylosis, by subcutaneous osteotomy, performed by himself and other members of the Society, more especially by Mr. Gant, Mr. Bryant, and Mr. Maunder.

All these operations, Mr. Adams remarked, are governed by the same general law, and their history forms but a portion of the general history of pathology and scientific surgery, amongst the latest and most practical improvements in which they form a prominent and important part.

Mr. Walter Coulson then read a paper on

LITHOTOMY AND LITHOTRITY IN THE LONDON HOSPITALS.

The author commenced his paper with a reference to an instructive address on surgery, recently delivered by Mr. Cadge at a meeting of the British Medical Association.

Mr. Cadge had obtained returns from eight of the principal London hospitals, which showed that each of these hospitals received, on an average, seven cases of vesical calculus annually. The object of Mr. Cadge was chiefly medical. He desired to ascertain the relative proportion of lithuria in different districts; but the author of the present paper considered the subject under its surgical aspects, and for his data relied on the reports annually issued by the four great hospitals, viz. Guy's, St. Thomas's, St. Bartholomew's, and St. George's. To these he has added the statistical information derived from the registers of St. Peter's Hospital for Stone, and the special departments in London and Paris.

Instead, however, of taking the numbers of vesical calculus, he has taken the operations performed for the cure of stone in the bladder—in other words, the cases of lithotomy and lithotrity.

The paper is accompanied by numerous statistical tables, which exhibit for each hospital the number of cases treated annually, during a period of five successive years, and the results thereof.

The following are some amongst the principal conclusions at which Mr. Coulson arrives from the statistics furnished in his tables.

Taking the broadest view of the matter, *i. e.* considering the general results of the two operations, massed together, the author finds that the number of cases of vesical calculus treated by operation in the four great hospitals already named, during five consecutive years, was 148, while the number of deaths was 24. The general mortality was therefore 1 in $6\frac{1}{6}$.

At St. Peter's Hospital during the same period the number of operations was 67, and the deaths 6, the general mortality being 1 in $11\frac{1}{6}$, or nearly one half.

This remarkable difference the author attributed to the kind of operation selected.

In the great hospitals lithotomy is the operation chiefly performed, while at St. Peter's the operation most frequently selected is lithotrity. This is a general view only.

The question of age must be considered if we institute a comparison of frequency between the two operations.

In some reports ages are given, in others not; but, allowing a proportion of one third for persons under sixteen years of age, the tables show that the proportion of adults cut in the great hospitals to adults crushed is as 82 to 29. Hence, lithotrity is applied to

one third of the total number of cases only. At St. Peter's, where the ages are recorded, the author finds that lithotrity is applied to three fourths of the cases operated on.

M. Civiale had, long ago, made the same remark, showing that the great hospital surgeons of Paris applied lithotrity to one third of their cases only, while he applied it to three fourths.

Several returns from large provincial hospitals seem to show a similar preference to lithotomy.

The preference, however, is more clearly shown in one of the tables, from which it follows that the total number of operations of lithotrity in the four great hospitals, during a period of five consecutive years, was 29; while at St. Peter's, during the same period, the number was 44, considerably greater than all the four put together.

Results, however, form the most important point to consider.

In the great hospitals, the death-rates of lithotrity and of adult lithotomy are nearly equal, being as 6 to 7. At St. Peter's lithotrity is twice as successful as lithotomy.

Again, the author shows that the reports of the four great hospitals give for lithotrity 28 cases with 5 deaths, while at St. Peter's the cases were 43, and 3 deaths.

Finally, the author brings to light a remarkable coincidence between the results of lithotrity, as applied in the three special departments at Paris, St. Peter's, and University College.

In the special department of the latter hospital the mortality of lithotrity is 1 in 16. At the Necker Hospital the mortality is 1 in 15·6 (for twelve years). At St. Peter's Hospital for five years the mortality is 1 in 14·3.

The paper concludes that the difference of results, so often exhibited by the tables, seems to point towards a neglect of lithotrity in the great hospitals.

Mr. Thomas Bryant failed to see the points in Mr. Coulson's paper that he wished to have discussed. He would like to have heard what class of cases should be selected for lithotrity in preference to lithotomy; neither could he see, except from Mr. Coulson's own statistics, in what degree the practice pursued at St. Peter's Hospital was superior to that of any of the general hospitals, and he thought that the cases treated were comparatively few, considering it to be a special hospital for urinary affections. The ages of the patients operated on were not stated, whereas upon this in a great

measure depended the success of the operation. Mr. Cock led the way at Guy's, and it was now generally followed there, to perform lithotomy at once in old people admitted in intense pain; if recovery did not follow he did not regard these cases as failures, the object being to give relief, and this was obtained.

Mr. Carr Jackson thought that Mr. Coulson's remarks with reference to the operation of lithotrity as pursued at St. Peter's, in London, would equally apply with the same justice to any other hospital, everything depending upon the age and condition of the patient. In his own practice he had operated thirty-three times, with the following results:—Lithotomy, twenty-five times, no death. Lithotrity, eight times, two deaths, one of which occurred from chloroform, and in the other case there was extensive disease of both kidneys.

Mr. Henry Smith felt that lithotrity was, as a matter of course, a much safer operation than lithotomy, and that, because Mr. Carr Jackson had performed twenty-five cases of lithotomy without a death, it did not follow that he might not meet with a run of bad cases, which would spoil his statistics. He remembered Mr. J. H. Green telling him that he had performed the same operation forty times without any bad result, and shortly after this he met with two or three deaths. He was surprised to hear Mr. Coulson say that lithotrity was an operation not commonly undertaken at the general hospitals. He hoped he was in error. Certainly, at King's College Hospital the crushing operation was very common, and the cutting was comparatively rare. He regretted that no information was given in the paper as to the indications for deciding which operation was to be performed.

Mr. Teevan knew that 2000 cases of stone had been operated on at the different London hospitals during the last twenty years, but no means existed for arriving at the statistics of them. He could only say that from Mr. Guttridge's returns in his book the mortality of adults after lithotomy in London is 50 per cent. It will be impossible to arrive at a correct estimate until every hospital publishes unreservedly its statistics.

Monday, March 20th, 1876.

WILLIAM ADAMS, F.R.C.S., President, in the Chair.

Dr. RICHARDSON showed an exhausting bottle made by Messrs. Krohne and Sesemann for embalming, but, he had found it to serve so many purposes, that many of the Fellows, he thought, would like to employ it. He had used it as an aspirator, and nothing could have answered better; a filling syringe could be affixed, and it answered the purpose of injecting. He had used it in stricture of the œsophagus, for feeding, and also for injecting the bowel. He thought it might also be used for transfusion, where a large quantity of fluid required to be injected into the circulation, as in cases of cholera, a mixture of blood and chloride of sodium. He also showed a new instrument for artificial respiration; he had shown several, but this was the most perfect. It was a modification of the double-acting bellows, in using which with adults we have to make so many strokes per minute that the efforts to restore life are frustrated. It is particularly useful in tracheotomy, where there is suffocation afterwards, not only in asphyxia, but where the muscles of the chest are worn out with heavy exertion; it was easy to adapt it to the tracheotomy tube instaneously. He lastly showed a tracheotomy tube, a modification of Dr. Fuller's, with a screw attached, by which the blades could be dilated after introduction. He (Dr. Richardson) took this opportunity to make the *amende honorable* to Mr. Henry Smith on a matter that occurred twenty-three years ago in this Society—a discussion on tracheotomy, followed by a paper discussion. Dr. Richardson had said that the operation was of no avail in many cases, because of the subsequent fibrinous deposits. Mr. Henry Smith took the other side, and his further experience proved to Dr. Richardson that Mr. Smith was right. The operation should be performed, for it gave the only chance of success.

Mr. ADAMS thought that the ability of keeping up artificial respiration would enable surgeons to undertake operations that would otherwise seem utterly hopeless.

Dr. ROUTH was gratified by the straightforward way in which Dr.

Richardson exhibited his valuable discoveries. He believed that the first instrument shown might be used for more purposes than had been stated; for instance, nitrate of amyl being an antidote for chloroform, the vapour of the same might be injected by this means.

Dr. DE HAVILLAND HALL asked whether in capillary bronchitis, where the lung is collapsed and the child dying, would not the instrument be of use?

Dr. BRAXTON HICKS would like to ask how far it would be expected that the air would extend into the lungs.

Dr. SEMPLE thought that there were a number of operations which failed on account of a false membrane having been formed in the larynx or trachea, there being no means of cure unless this membrane could be drawn out. He had been struck by a communication from Sir John Cormack, which showed that in certain cases a false membrane had been observed about the tonsils and uvula, and an operation being considered necessary, the prognosis on this account was given unfavorably.

Dr. THEODORE WILLIAMS asked whether it would not be better to employ oxygen for injection in place of atmospheric air.

Monday, March 27th, 1876.

WILLIAM ADAMS, F.R.C.S., President, in the Chair.

Mr. HENRY SMITH read a paper on

SOME MANIFESTATIONS OF CONSTITUTIONAL SYPHILIS.

He commenced by stating that he did not see the very severe cases of secondary and tertiary forms of this disease as we did some twenty-five years ago, and he attributed this in a great measure to the advance of our knowledge of the pathology of the disease, and the extraordinary improvement in the treatment of the various forms of syphilis. He wished to call attention to two points in particular in connection with syphilis. The first was that very frequently certain manifestations of a more or less severe character

exhibited themselves in individuals when there was either no history of syphilis at all, or where there was no clear evidence of its having existed, and yet it was evident from the nature of these manifestations that they could depend upon nothing else except the introduction into the system of the syphilitic poison. These manifestations consisted mainly of intractable ulcers of the skin, which either existed alone or were combined with other phenomena, such as wasting of the muscles and a painful condition of the joints. Some severe cases of this character were mentioned. In some of these cases there was no history whatever of this exception of the syphilitic persons, and in others there was the history of long antecedent disease. The second point which the author wished to bring prominently before the Society referred to the treatment of these cases, and especially to the results of very large doses of iodide of potassium. He had found that in the cases in question there was a marked amount of constitutional cachexia, and confirmed debility, and it was a remarkable fact that ordinary tonics, and general remedial measures, had no effect whatever in removing this cachexia, but that directly the system was brought under the influence of iodide of potassium, given in very large doses, the constitutional cachexia was removed, and at the same time the specific manifestations disappeared. It was absolutely necessary, however, to give the iodide of potassium in very large doses, for he had met with instances when the remedy had been given for a long time in the ordinary doses, and no benefit whatever had occurred; but, after the exhibition of the large doses, the symptoms were removed. Thus, the iodide of potassium, given in large doses, not only acted beneficially in curing the disease, but, it was of the greatest use to us in helping to establish our diagnosis in doubtful cases.

Dr. Drysdale thought that the present matter brought forward was more practical than in the discussion lately held at the Pathological Society on the same subject. If a patient has a mild attack of secondary symptoms he is much more likely to have a very severe tertiary disease following; and, again, if a patient be seen suffering from an aggravated form of tertiary syphilis he probably does not remember having had any secondary disease at all. From this might be adduced the prognosis that a patient suffering from a severe form of secondary affection may escape subsequent trouble. In cases of hereditary syphilis, assuming a tertiary form, he believed that iodide of potassium was just as useful as in acquired syphilis.

He was not quite certain that we ought to so readily put aside sarsaparilla, after so great a writer and admirable observer as Mr. James Lane had so strongly advocated its use. It certainly did no harm, if it did not benefit. His opinion also was that syphilitic phthisis was a well-marked disease, although it had been denied to exist.

Dr. Semple thought that one third of the cases applying at the Throat Hospital were of syphilitic origin. When iodide of potassium failed entirely he had found sores rapidly heal under the administration of mercury; as a rule he commenced with iodide of potassium. Local treatment had not been alluded to in the paper. He could not imagine why nitrate of silver had been omitted in this regard. In ulceration of the throat he considered it a most important element.

Dr. R. J. Lee would ask the President to call upon Mr. Smith to read again the two points which he had so clearly stated he wished to be discussed. The attention of the Society should be confined to these.

Mr. Francis Mason remarked that, in the first place, he could not subscribe to the opinion now somewhat prevalent in the profession, that because the administration of iodide of potassium is followed by a successful issue, therefore the case is necessarily of a syphilitic character. He ventured to think that in the cases which Mr. Smith had narrated a clear and decided history of true syphilis had not been made out. No doubt many persons presented themselves with serpiginous ulcers which yield very rapidly to the treatment referred to by the author of the paper, but he (Mr. Mason) could not call to mind a single instance in which a patient had been under his own observation from the first with a true infecting sore, followed by a secondary eruption, who had subsequently applied to him suffering from serpiginous ulceration. He believed such cases to be rare, and he came to this conclusion after nearly fifteen years of hospital and other practice. Mr. Mason then referred to a patient at St. Thomas's Hospital, who had exfoliation of the palate bones and of portions of the superior maxillæ, to whom large doses of iodide of potassium were given with some benefit at first; ultimately, however, ulceration of the larynx occurred, for which it was considered necessary to perform tracheotomy. In this case, as in many others of a like kind, there was no direct history that the patient had ever had a true infecting sore, or syphilis in any

form whatever. He would like to ask Mr. Smith if he had thoroughly investigated the history of his cases.

Mr. Lennox Brown saw cases constantly of secondary eruption in the throat which got well with or without medicine, and came back with tertiary symptoms. He considered it absurd to conclude that iodide of potassium could only do good to cases of a syphilitic nature. There were many strumous affections which it relieved, but he had no doubt that in ulceration of the throat, where temporary relief was at once obtained, they were syphilitic.

Mr. Gay said Mr. Smith began with a very important point, that syphilis nowadays is a very different thing to what it was a great many years ago. What has constituted the difference? Does it exist in the poison? He believed, no; but that it depended on the nature of the soil on which it was planted. He thought every one should form some theory of the disease before determining on the treatment. When the disease affected the ganglionic system he believed mercury to be the best thing; when the skin, or testicle, iodide of potassium. Local applications should not be overlooked. He thought that when the system was exhausted in cases of rupia the pernitrate of mercury would cure without the internal administration of medicine.

Mr. Royes Bell knew how with secondary eruptions before him he had found it impossible to get a history of a primary sore. Numerous cases occur which one has no doubt are of syphilitic origin. After every other drug has failed iodide of potassium is prescribed, and they get well. Whether acquired or hereditary, he had no doubt of the nature of the affection.

Dr. Wiltshire thought that the ammonio-citrate of iron with sal volatile, if combined with the iodide of potassium, its action is much strengthened. He believed, speaking broadly, that mercury is much more useful in the early stages of the disease, iodide of potassium in the latter.

The further discussion of the paper was adjourned until Monday, April 3rd.

Monday, April 3rd, 1876.

William Adams, F.R.C.S., President, in the Chair.

Dr. Sansom then opened the discussion on Mr. Henry Smith's paper on "Some Manifestations of Syphilis." He stated that of the two opposite views taken he agreed with the author of the paper, and disagreed entirely with Mr. Mason. We frequently see in large general hospitals women whose symptoms are supposed to be dyspeptic, then to be due to pleurodynia, and later on to be syphilitic, and yet no history of a primary sore can be obtained; they are treated by iodide of potassium, and get rapidly well. It must be illogical to think these cases are anything else than syphilitic. He would like to ask Mr. Mason what is struma? He, though constantly hearing it spoken of, did not understand the nature of the disease. When the term "strumous" is applied to children, all that Dr. Sansom has found has been a lymphatic temperament, with a proclivity on the part of the adenoid tissues to undergo rapid disorganization and suppurate. There is no evidence to show that iodide of potassium will ever do good to these cases.

Dr. Cook thought that much ill-feeling and unhappiness in families would arise if medical practitioners made it a practice to inquire, without exercising considerable discretion, as to whether the patient had suffered from primary syphilis. He would suggest the following rules:—In all cases in which the nerve tissues, as the brain and spinal cord, are affected, and also when nodes exist, he would give iodide of potassium; whereas in cachectic states of the system, with loss of flesh, &c., and in all cases in which the skin is involved, he would give mercury. He thought that, except in special cases, where it was desirable to flood the system speedily, small doses of iodide of potassium answered better than large ones. He generally gave three-grain doses combined with quinine and tartrate of iron; he always found this act most beneficially.

Mr. Henry de Meric considered that it was not to be wondered at that no history of primary disease could be obtained, considering how painless and unobservable are many primary sores, especially in women; they frequently heal rapidly without treatment, and

causing no pain, escape notice. He did not agree that any definite rule could be laid down as to when mercury, and when iodide of potassium should be given in tertiary syphilis, but thought mercury should be given when iodide of potassium failed.

Dr. J. Milner Fothergill said that he had often noticed conditions of anæmia and arrested growth in which the administration of the ordinary tonics were inoperative, until mercury was added. He thought too much importance was attached to the patient's statements, and often it was desirable to proceed at once to the therapeutic test. He had not experienced any difficulty in giving mercury over extended periods in anæmia, or cachectic syphilis, if it were combined with iron, and liberal supplies of good food. It was important to support the system during the mercurial course, by which the bad effects of the mercury were obviated. In cutaneous syphilis the local application of mercury was useful. He deprecated the present reliance on iodide of potassium, and advocated the greater use of mercury.

Dr. Routh, speaking first as to the difficulty of finding a syphilitic origin in the history of cases, said it often arose from one refusing to ask the necessary questions; everything needful may be asked in quite inoffensive language; to get the proper information was the patient's safeguard. He knew that there were many other ways of communicating the disease than by the generally accepted one, in proof of which he gave two instances. In France this was better known. He remembered a lecture which he had heard from M. Ricord thirty years ago, in which revelations as to the propagation of the disease had been made which had astonished, and horrified him. He considered it a very unphilosophical argument to maintain that, because mercury and iodide of potassium cured where other medicine failed, therefore the disease was necessarily syphilitic. Numbers of skin diseases, erythema nodosum for instance, and many forms of rheumatism, were cured by these remedies. Does this prove that they are of syphilitic origin? The supporters of this theory were compelled to make an assertion at which the College of Physicians and Surgeons would be astounded—that there is no such disease as struma or scrofula. With regard to nodes, are they evidence of syphilis? In his student days Messrs. Cooper and Liston taught that they were due to the abuse of mercury. It was well known that iodide of potassium was the best remedy for these abuses. Salivation from the one drug was always best treated by

the administration of the other; and who could say that the salivation was syphilitic?

Mr. Richard Davy said that Mr. Henry Smith had put forward two truisms for discussion. In diagnosing syphilis a truthful patient can render aid to the surgeon, and no false modesty should exclude plain and blunt English from the cross-examination. In inherited syphilis verbal testimony is useless. If it be a "wise child that knows its own father," it must take a wiser to state its father's diseases; and here the practical and able observations of Mr. Hutchinson are invaluable, and more will yet be learnt in this field with regard to the treatment of syphilis. We do ourselves and the public wrong in discussing it as curable; our best doings do but patch it up. Such a belief not only offers instances of human credulity, but also diverts our attention from the true remedy, namely, its prevention.

Dr. Wiltshire begged to ask Mr. Davy whether he believed that the same patient could contract syphilis on a second occasion. He was sure that such could be the case, from which he concluded that the system had been cleared from the original virus.

Dr. Farquharson considered that syphilis may be now and then entirely eradicated from the constitution, and that such had been proved by the interesting series of cases of reinfection presented to the Royal Medical and Chirurgical Society by the late Mr. Gascoyen. He believed that early and systematic treatment by mercury favoured this desirable termination. Syphilis in these days is a much milder disease than it was in former times, partly on account of the wearing-out of the poison from repeated transmission, as in the case of the vaccine lymph and the eruptive fevers, and partly from specific treatment during a long series of years. Untreated syphilis, as in Algiers, showed an excessive degree of virulence. He attributed no importance to the history given by the patient; for one had not only to deal with deceit, but also with ignorance and want of observation. He considered such history ought to be unnecessary, for there is no reason why we should not diagnose advanced syphilis from its symptoms alone, as we are compelled to do in the infantile form of the disease; and, in typhoid, or measles, he also recognised the great assistance to be derived from a therapeutic test.

Mr. Donald Napier did not believe that there were any conditions of the teeth diagnostic of syphilis. Notched or honeycombed

teeth he considered as frequently the result of mercury and scrofula.

Dr. Gibbon believed also that the notched and the round peg-shaped teeth, as described by Mr. Hutchinson, are not pathognomonic of inherited syphilis. He could not agree with Dr. Farquharson that syphilis, like vaccinia and the other specific fevers, was wearing out. He considered that the seed was as active and potential as ever, but that the soil was perhaps less adapted to its development. He thought that some cases of tertiary syphilis might be traced to so-called gonorrhœa. In his own practice he had met with two cases of the kind; the worst cases of the disease he had seen appeared to be due to a combination of syphilis and mercury. He related the case of a lady who had been infected on the side of the nose by a child suffering from inherited disease. Mercury was administered with apparent benefit at first, but subsequently was followed by nodes on the head, and necrosis of the ulnar and superior maxillary bones, and this in spite of the lavish administration of iodide of potassium. The mother of this child, the woman's sister, who had had no specific remedies whatever, had, on the contrary, suffered but very slightly from the disease.

Monday, April 10th, 1876.

William Adams, F.R.C.S., President, in the Chair.

Mr. Francis Mason exhibited a man, æt. 62, on whom he had operated three times for a

MYELOID TUMOUR OF THE SEPTUM NASI

with a good result. In the first operation, which took place September 9th, 1874, the growth was removed through the anterior nares, with the ordinary polypus forceps; the nostril, however, soon became again obstructed, and therefore on the 26th September Mr. Mason made an incision down the side of the nostril, and raising the ala extirpated the growth. The patient went on well until Christmas, when the tumour was again manifest, being larger than ever. On January 6th, 1875, Mr. Mason operated for the third

time, by carrying the knife in the line of the cicatrix left from the previous operation and dividing the upper lip in the median line, he succeeded in entirely removing the growth from the septum of the nose, and as the tumour had invaded the upper lip a portion of the inner surface of this was excised. The patient had remained quite well ever since—a period of fifteen months. Mr. Mason then referred to a case, with photographs of the patient, of melanotic tumour on the right cheek of a man, æt. 64, which was removed on October 23rd, 1872, at St. Thomas's Hospital. There were numerous submaxillary glands involved, to remove which a fruitless attempt was made. Notwithstanding this the man made a rapid recovery, and Mr. Mason had last month received information that he had remained perfectly well up to the present time (*i. e.* during a space of three years and a half), and that he intended coming up to London on Good Friday in order to satisfy Mr. Mason as to the successful issue of the case. Mr. Mason brought these cases before the Society with the view of indicating the expediency of operating on tumours, which from their general appearance and microscopic character appear to be beyond surgical aid.

The PRESIDENT congratulated Mr. Mason on the extraordinary success which had attended these operations, and thought that many surgeons would have interfered with great reluctance, on account of the constitutional origin of the disease, myeloid being even worse than melanotic.

Mr. KNOWSLEY THORNTON had noticed many tumours of the ovary, which from their histological character one would expect to recur after removal, and certainly such would be the case in any other part of the body, and yet, if the operation be performed before the peritoneum has become affected, no recurrence takes place.

Mr. SPENCER WATSON thought myeloid sarcoma was rarely found in the situation described by Mr. Mason; it generally springs from the interior of bones, and not from such a part as the septum nasi. He would suggest that it might possibly have originated from the upper jaw. There was an operation originated by Dr. Rouge, of Lausanne, by which free access to the nasal cavity is obtained, with even less disfigurement to the face than that occurring after the operation as performed by Mr. Mason.

Mr. HAINWORTH referred to the common occurrence of melanotic tumours in horses of a grey colour, which, though multiple in the same subject, had no appearance of malignancy.

Dr. Routh had observed melanotic cancer in grey horses, especially about the anus and vagina, and had found on inquiry that if bred from, the offspring, unless grey, did not suffer from the disease.

Mr. J. Knowsley Thornton, after a few words of introduction, gave a brief account of

TWO UNUSUALLY SEVERE CASES OF PELVIC HÆMATOCELE,

which had been under his care at the same time in the Samaritan Free Hospital. In both cases the effusion of blood gave rise to a large abdominal tumour, and in both the patients were very ill, and in danger, before any surgical measures were adopted. The one case was treated by successive punctures from the vagina immediately behind the cervix, the opening eventually being kept patent to allow drainage. The other was treated by free incision in the same place. Each case was for about five weeks under treatment, and each had relapses due to imperfect escape of the discharge from inefficiency of the measures taken to establish free drainage; both ultimately recovered and continued well, very little trace of the effusion or attendant cellulitis remaining. Mr. Thornton then made some remarks on the special points of interest in the two cases. He advocated free incision and drainage by the vagina in all cases where surgical treatment became necessary in preference to simple puncture, and, he objected to injections, unless there was evidence that the collection had become thoroughly encysted and putrid. He would not advocate a too hasty use of surgical means, but thought there were cases, when the effusion was very large, where it would be better to incise and drain, even though no serious symptoms were present, as the treatment was thus rendered much shorter, and there were many risks in waiting. He quoted from the works of Sir James Simpson and Mr. Spencer Wells in support of the advisability of free opening, and drainage, in many cases. He advocated the use of the hollow tangle tent in preference to other forms of drainage tube. Referring to the published papers of Dr. Meadows on this disease, he protested strongly against puncture per rectum as dangerous, from the risk of admitting fæcal gases or liquids through the opening, and as also objectionable because, if a fistula became established into the bowel, it was out of the reach of the surgeon for further treatment. He also referred to the opinion

of Dr. Meadows, that the blood was fœtid before puncture, and pointed out possible sources of fallacy from Dr. Meadows' published cases. In both of the operations he had mentioned the blood effused had been found in the first instance inodorous. In conclusion, he acknowledged imperfection in the treatment of his cases, due to the variety of views, and deficiency of good guides, in published cases. He trusted that the careful record of two cases successfully treated would prove useful.

Dr. Rogers considered that there were a limited number of pelvic hæmatomas which required surgical treatment. The paper of Dr. Meadows, published in the 'Obstetrical Society's Transactions,' proved that the "rest-and-be-thankful" treatment could not always be relied upon. Dr. Rogers had brought before the Obstetrical Society a most interesting case, which so simulated a fibroid tumour of the uterus that no less than five experienced physicians were deceived in the diagnosis. Suddenly, rupture took place, resulting in death. This case induced a distinguished Fellow to say that it had caused him to modify his opinion, and to determine him in future in certain cases to adopt a more active treatment. Dr. Rogers did not agree with the author that it was unwise and dangerous to tap per rectum. He had seen the best results from such treatment. In one case nature effected a cure by a rupture in this situation, the opening caused thereby allowed a long elastic tube to be passed into it, and injections of carbolic acid to be employed.

Dr. Routh said he was compelled to be at issue with Mr. Thornton on several points:—(1.) He had omitted all notice of diagnosis; in some chronic cases he considered it next to impossible to distinguish between fibroid of the uterus, pelvic cellulitis, and hæmatocele. (2.) In the cases quoted the patients had passed through a desperate condition before recovery, the hæmatocele had first been converted into abscess, and pyæmic poisoning had subsequently occurred. Was it wise to run this risk? Dr. Routh did not approve of opening these hæmatoceles any more than abscesses through the vagina, and for these reasons—during inspirations the uterus and the vagina descended, while in expiration they ascended, and the great tendency of air rushing into the vagina, when the external opening was patent, was well known to all who used the duck-bill speculum. If, then, there were a sufficiently large opening through the vagina, air would certainly penetrate into the hæmatocele, and give rise to fœtid pus, and poisoning. He

advocated puncture by the rectum in preference, believing that the sphincter ani acted beneficially in keeping the canal closed. If a drainage tube had to be used in preference to the one employed by Mr. Thornton, which was constantly coming out, he preferred one of Holmes' large caoutchouc catheters, which were self-retaining, and admitted injections to be used.

Dr. Godson was glad that Mr. Thornton had laid stress in his paper on the extreme rarity of cases requiring surgical interference. The disease was now recognised as anything but uncommon. The fact that, a week or two since, ten out of the twenty-one beds at St. Bartholomew's Hospital set apart for the diseases of women were occupied by cases of pelvic hæmatocele, was sufficient proof of this. Out of the large number of cases seen by Dr. Godson during the last ten years, in only two or three had the effused blood extended above the brim of the pelvis, and with very few exceptions a cure had been effected without surgical treatment. He considered such interference unwise unless there were urgent symptoms, such as uncontrollable vomiting, calling for it. If it were determined that something must be done, a small puncture, allowing even only a drachm or two of fluid to escape, would probably be sufficient to relieve the distress, and further surgical treatment be rendered unnecessary. He had never seen any harm arise in tapping per rectum, and would select this channel in preference to the vagina, should there be any distended part in it where fluctuation was more distinctly felt. The fluid evacuated resembled port wine, and did not coagulate after being drawn, the clotted portion remaining behind, and this prevented the benefit of an aspirator, for it would be directly drawn into the tube and stop it up; this had been demonstrated lately at St. Bartholomew's. Dr. Godson attributed the successful issue of the large number of cases he had seen to the rest which had been enforced upon the patients immediately after the detection of the disease, and he thought that, in all probability, if Mr. Thornton's first patient had not been allowed to return home after being seen, the case would never have assumed such gravity. He had seen a blood tumour, sufficiently large to distend the perinæum, and push the uterus up out of reach, entirely disappear of itself, perfect rest only being enforced. The fact of the displacement of the uterus he considered sufficient proof that the effusion was subperitoneal.

Monday, April 24th, 1876.

WILLIAM ADAMS, F.R.C.S., President, in the Chair.

DR. JOHN COOK showed a patient, a girl, æt. 4 years, who had suffered since September last from a cutaneous eruption, mostly on the limbs, which occurred in the form of vesicles resembling those produced by vaccination, several of which would occasionally run together, forming large bullæ; fresh crops kept arising from time to time. The vesicles became umbilicated on the fourth day, and on the sixth or seventh pustular, subsequently forming a brown scab. He considered the case one of chronic umbilicated pustular varicella.

Dr. SEMPLE read a paper—

ON THE PATHOLOGY AND TREATMENT OF CEREBRAL DISEASE.

The author commenced by observing that cerebral diseases might be studied in two distinct modes, namely, either by classifying these affections in a nosological system, which must necessarily be artificial, or by taking them as they occur in nature, independent of all technical arrangement. The former plan is best adapted for the student in order to make him acquainted with certain mental pictures or types of disease; the latter is more useful to the practitioner, who must examine every case as it presents itself to his notice, and who must often by such experience correct or contradict the doctrine taught in books. All nosological arrangements are necessarily faulty, and all dogmatic principles of treatment must be disregarded, because, although the features of disease are essentially the same, the modes of detecting their real nature is ever varying, owing to the increased spread of knowledge, and to the more exact methods of medical investigation pursued in the present day. In reference to the pathology of cerebral disease, the introduction of the ophthalmoscope has literally thrown a vivid ray of light into one of the darkest chambers of medicine, and has enabled the surgeon and

the physician to infer, from the condition of the retinal vessels, the existence of structural changes in the cerebral arteries calculated eventually to lead to a host of diseases which under various names, such as apoplexy, ramollissement, epilepsy, coma, &c., may threaten the integrity of the vital and intellectual functions or cut the thread of life asunder in a moment. In therapeutics, too, a complete revolution has been wrought in the treatment of the diseases in question, partly by the guidance of scientific principles, partly by the scepticism (using the word in its etymological sense of *contemplation* or *meditation*) of the present age, and even the success of some forms of quackery has afforded useful hints to the conscientious inquirer after truth.

It is universally admitted that the pathology of cerebral disease is still involved in great obscurity in many respects, and it is well known that some of the most serious diseases of the brain may exist, and reach a fatal termination, without giving any appreciable notes of warning during the life of the patient. On the other hand, some slight derangement of certain parts of the cerebral mass may give rise to the most alarming symptoms. Reference was then made by the author to the post-mortem examination of a distinguished member of the profession, who had recently died, and in whose brain a large tumour was found which had been wholly unsuspected during life, either by the patient, or by his medical friends. When symptoms of brain-disease exist during life the seat of the malady is often indicated by the objective manifestations afforded by the nervous cords, which form the media of communication between the central cerebral mass and the external world. Thus, lesions of the motor or sensory track, respectively, will give rise to appreciable impairment of some function, or to the production of paralysis or pain, and, indeed, the existence of paralysis in some part is one of the most important indications of cerebral lesion. But, if the part of the brain affected be not situated in the track of the sensory or motor fibres, there may be no paralysis at all, even although the disease be very extensive. In illustration of this remark the author related a case in which, although there were undoubted indications of cerebral disease during life, there was no paralysis. On post-mortem examination, a large cavity of about the size of a hen's egg was found near the surface of the brain, filled with a clot of blood, and opening on the upper part of the hemisphere. The absence of paralysis was thus accounted for,

inasmuch as the seat of effusion was out of the track of the ordinary motor and sensory nerves. In this case the author observed during life a persistent contraction of the pupils, a circumstance which he believes to indicate the existence of irritation on the surface or periphery of the brain, while, on the other hand, he has found that a continuous dilatation of the pupil is an almost unerring test of effusion of fluid into the ventricles, or between the membranes. In ordinary apoplexy, however, and in some other dangerous and analogous conditions of the brain, it is common to find one pupil contracted and the other dilated. Another case was then related in which the symptoms of cerebral disease were well marked during life, but were apparently relieved for a time by treatment; but after death a combination of morbid appearances was discovered in the brain, as congestion of the membranes, effusions of serum, an apoplectic cyst, and softening.

With respect to the important question of treatment in such cases as those described, Dr. Semple proposed to offer some observations, but disclaimed the expression of any dogmatic views. In some cases it is evident that no treatment can be of any avail, but even in some of the worst there is often a gleam of hope. It must not be forgotten that although certain symptoms observed during life often denote the presence of serious intra-cranial mischief, yet the same symptoms may present themselves in cases where the brain is perfectly healthy. Apparent apoplexy has sometimes depended on kidney-congestion, and has vanished when that congestion has been relieved; coma and convulsions have often ceased, as if by magic, on the expulsion of an intestinal worm; cerebral congestion in a female has been relieved by the appearance of the menstrual discharge, and spurious hydrocephalus has disappeared on the cutting of a tooth. But, even where there is actual disease within the cranial cavity, it by no means follows that the malady is incurable or hopeless. Mere congestion of the brain, though often fatal, is frequently relieved by appropriate treatment, and even when rupture of a vessel has occurred, and extravasation has ensued into the cerebral mass, a cure may still be effected. For, in such cases, nature will often absorb the effused blood, and, though a cyst may remain, the brain may be restored almost to its normal condition.

In former times the universal rule of treatment, in such cases as those just alluded to, was to bleed the patient to a large amount, and the practitioner who neglected this measure was considered

guilty of malpraxis. Some years since a distinguished physician incurred very general censure for not bleeding a medical friend with whom he happened accidentally to be travelling, and who was suddenly seized with a fit of apoplexy, of which he died. In the present day the censure would probably be bestowed if a practitioner were to adopt first the opposite course. But in either case the censure would be unjust, for a number of fatal occurrences are really due to causes over which human art has no control, and in many cases of apoplexy the result is necessarily unfavorable. The true rule of treatment probably lies between the two extreme views which have been entertained in the present century, and may be laid down as follows:—When the attack is quite recent, and the pulse is full, hard, and strong, the breathing stertorous, and the patient plethoric, the absence of blood is admissible, and in all probability will be beneficial. If, on the contrary, the patient be weak and anæmic, the pulse feeble, and there be a tendency to syncope, bloodletting will only accelerate the fatal result. Even, in cases where the pulse appears to admit of bleeding, the effusion may be so extensive that all chance of recovery is lost, but it is to be remembered that the amount of effusion can be proved only after death, and, although that event has happened, it does not therefore follow that the bleeding has been injurious. Dr. Semple then adduced some cases in support of these views, and observed that he had written out and published so many cases of post-mortem examinations occurring in his own practice, that he could not be accused of attempting to paint his experience in cerebral diseases with a *couleur de rose*, or of pretending that bleeding or any other treatment was a *cure* for apoplexy. But, he adduced the cases as honest records of the consequences of treatment, and although he did not even assert that the patients would not have recovered if no depletion had been practised, yet he thought he might confidently declare that the measure did no harm. The cases brought forward were three in number, two being in old subjects, and one in a plethoric vigorous man, but in all the bleeding appeared to be decidedly beneficial, and the patients completely recovered. Dr. Semple adverted to the fact, which he thought worthy of attention, that he saw all the cases almost immediately after the seizure, and that the bleedings were performed at the very outset of the malady.

Mr. Jabez Hogg stated that very frequently early indications of

cerebral disease were detected with the ophthalmoscope ; choking of the disc, the periphery especially, with very little destruction of vision, was observed in these cases, and, if such were noticed before the occurrence of cerebral symptoms, a very careful dietary should be enforced, which might possibly ward off the attack.

Dr. John Cook remembered several cases in which there had been large lesions of the brain, without the physical symptoms of the same having occurred during life.

Dr. Wiltshire then read a paper on

RUPTURE OF THE PERINÆUM, WITH FÆCAL INCONTINENCE, DUE EITHER TO PARTURITION, THE PASSAGE OF LARGE TUMOURS, OR FROM DIRECT EXTERNAL INJURY.

" Rupture or laceration of the perineum is an accident mostly due to parturition. It has, however, been known to occur in the non-pregnant from the passage of large tumours, and also from direct external injury.

As regards lacerations caused by the passage of large tumours it may be remarked that, generally speaking, they are avoidable, for as the growths in question are for the most part fibroid tumours of the uterus, their size, when unduly large, may usually be reduced by making sections of them by means of the wire écraseur.

I do not propose entering into the consideration of the modes in which the accident may be produced during parturition, nor of the means to be adopted for its prevention, since that would occupy too long a time, and, moreover, is unnecessary for our present purpose.

What I now desire to do is to consider the best means of restoring the integrity of the torn perineum, and sphincter ani, when the rent has ripped open the lower end of the bowel.

The class of cases, then, to which I wish to direct your attention is that in which the perineal rent has extended through the anal sphincter into the bowel, incontinence of fæces and flatus, of course, resulting. The condition of the unfortunate patients in whom this has occurred is a very sad one. Generally, they are young mothers who have had the misfortune to be badly torn in their first labour, and thus at the very outset of the most important epoch of their lives as wives, and mothers, they become not only

incapable of comfortably performing the ordinary functions of wife and motherhood, but are rendered loathsome to all around them. It requires no effort of the imagination to picture the misery, constantly renewed and intensified by repetition, which a sensitive and delicate-minded young wife must feel under such circumstances. Never knowing a moment that she may not be unwittingly disgusting to her husband and friends, unable to leave the house, and even unfit to sit in the company of friends in her own house, she is a prey to trouble of a most distressing kind. Those who have met with this affliction in the person of a refined young woman will know how keen is the distress it occasions.

It may be wondered that such a distressing condition is allowed to continue long after its occurrence without attention, but in my experience it has appeared that the existence of the accident has not uncommonly been unknown for a considerable time after delivery; the fact of there being a tear of any serious magnitude having unfortunately escaped the observation of the accoucheur during the confinement, and from the young wife's ignorance of matters relating to childbearing, and her natural reticence, and delicacy, it not unfrequently happens that the poor sufferer puts up with, and conceals her infirmity, until it becomes unbearable, or betrays itself by the offence it gives to others. Then, perhaps, an examination is made, and the nature of the trouble is revealed.

When we attentively examine the injured parts we see that not only is an operation absolutely necessary for the repair of the mischief, but that to restore the parts to their functional integrity it should be of such a character as to reconfer the power of controlling the sphincter. The question is, Can this be done? To the best of my knowledge the direct restoration of the functional integrity of the sphincter by operation has never before been attempted. In an imperfect and indirect way something is done in this direction in the ordinary operation for ruptured perineum, the excellent results from which yet fall considerably short of what I think is attainable, and at any rate certainly ought to be aimed at. The procedure I have successfully adopted, and now advocate, I believe achieves this result. It is an addition to the ordinary operation, and is not difficult of accomplishment, as will be presently seen.

The extent to which the bowel is torn is a point of some importance in respect to the operative procedures which may

become necessary. Thus, when the rent extends an inch or more up the rectum the edges of the torn bowel should first be pared, and then neatly brought together by fine silk sutures, the ends of which may be left in the gut. It has been recommended that this part of the operation should first be performed, some weeks being allowed to elapse before proceeding to the complete restoration of the perineum. I am myself disposed to think that it may be well, if possible, to complete both operations at one sitting, but there may be circumstances which render this undesirable.

It is unnecessary to detain you with a description of the anatomy of the parts, for you are all familiar with it; it is sufficient to remember that with the rent the muscles which find attachment in the perineum lose their support, and that the sphincteric tissues controlling the lower end of the bowel are rendered powerless.

But, in speaking of the anal sphincter, it is as well to point out that there are practically two sphincters at the lower end of the bowel; one, the distinct muscular ring, which can be readily seen at the margin of the anus; and another just within the bowel, formed by the band of circular fibres surrounding the extreme end of the gut. These together control the bowel, and it is the restoration of their integrity that is aimed at by the operation I would recommend.

When the tear takes place the torn ends of the sphincter retract, just as the ends of a tightly stretched india-rubber ring would do if the ring were cut across. The shrunken sphincter can be both *seen* and *felt* as a thick cord of tissue at the posterior margin of the anus. Though retracted and shrunken it still exists, and it is obvious that, if the broken ring could only be joined together again, it would put the patient in a fair way to regain the control which was lost when it was severed. The object of the operation is to bring the two horns of the crescentic-shaped mass of muscle together again, and this is how I have accomplished it in the three operations I have done.

After the usual operation has been performed, by vivifying the surfaces of the torn parts, I cut down upon the stumps of the sphincter by means of the scissors, the stump being pushed upwards between the blades by the fingers and thumb of the left hand. Then, in inserting the sutures I put one, the lowest, in such a manner that when tightened it shall bring the cut ends of the sphincter together again. This is done by inserting the needle

higher up in the buttock than the sphincteric level, then dipping it down and picking up the first end of the sphincter, riding across the bridge of bowel tissue, dipping down upon the second end of the sphincter, and bringing the needle out again at a level corresponding with its entrance into the buttock on the opposite side.

Reflecting on the character of the injury, and the objects to be borne in mind for its reparation, it struck me that, besides bringing together the torn edges of the perineal structures, as in the ordinary operation, one should, if possible, aim at the restitution of sphincteric integrity, since the loss of that constituted the gravest part of the trouble suffered by the unfortunate patient. Not to have control over the bowel (anal sphincter) is, perhaps, one of the most distressing afflictions a human being, otherwise in good health, can suffer from, and it is peculiarly distressing to those who are commonly the sufferers, viz. young wives. The disgusting attendants upon this condition, constant escape of fæces and flatus, are most distressing. The mental misery and bodily discomfort make life a burden scarcely bearable, and this is not lessened by the knowledge that their state may render them an object of loathing to those who are nearest and dearest to them.

In endeavouring to carry out the idea, suggested to me by actual observation of the injured parts, it occurred to me that one ought to aim at bringing together the torn and retracted ends of the sphincteric tissue. This I set myself to accomplish, and have carried into effect in three cases with, I am glad to say, very gratifying success.

The first case, a lady, aged about twenty-four, was injured in her first labour, when instruments were used. The perineum was torn into the bowel with the usual result—fæces and flatus were constantly passing, and there was no control over the bowel. Having pared the edges in the usual way I endeavoured to bring together the stumps of the sphincter, adopting the plan delineated in the diagram. The result was very satisfactory.

The next case in which I resorted to this operation was that of a hospital patient, a multipara, and here again the plan answered admirably, very great power having been gained over the bowel.

The third case was seen in consultation with Mr. Harrison, an old pupil of St. Mary's. This lady, the wife of a solicitor, was injured in her first labour, but the injury was never discovered by

her medical attendant, and she went on until her second labour, suffering much from want of control over the bowel. In her second labour the injury was aggravated, so that absolute incontinence of fæces and flatus resulted. This poor lady's condition was most distressing. She was a strong and healthy young woman of twenty-six, but owing to her infirmity she could never leave the house, and, in fact, could not sit in the company of her husband or friends, the escape of the contents of the bowel always rendering her an offence to those near her. I performed the operation I have described, and in spite of troublesome piles, and retroflexion of the womb, the result has been admirable.

I cannot help thinking that the procedure advocated will be found to yield better results than those afforded by the ordinary operation, and that the principle of bringing together the torn ends of the sphincter, which, so far as I know, is new, should be borne in mind in all operations for the relief of fæcal incontinence caused by severe rupture of the perineum, involving the anal spincter. It may be that, though practically we shall, when successful, make a new sphincter, it will not be as perfect as the original one before its integrity was destroyed, still it gives a result which, compared with the previous condition, is an incalculable gain, and an enormous comfort to the patient.

In conclusion I would say that, as the parts contract during cicatrisation, and as that process continues over several months, the results improve greatly with time. This is probably also in part due to improvement in the innervation of the tissues, the command over the sphincter being regained as repair goes on, and doubtless improving with use."

Dr. John Brunton said that no ruptured perineum, as described by Dr. Wiltshire, should exist. It would have been avoided had stitches been put in at the time of the delivery.

Dr. Routh thought that, when both sphincters were torn, which cases were the worst, the operation recommended by Dr. Wiltshire would not be of much use. He preferred Mr. Bryant's plan of taking up a tongue-shaped piece of tissue.

Dr. Rogers always performed the ordinary operation as introduced by the late Mr. Baker Brown, and had never met with any difficulty in the fæces being retained after the operation, and he failed to see any benefit in Dr. Wiltshire's operation over it.

Dr. Heywood Smith had, by making an incision in a similar way,

though not by dipping down as in Dr. Wiltshire's cases, performed the operation with success at the Hospital for Women. He was accustomed to use a needle with a very large curve. He thought the ordinary silver wire possessed many advantages over the twisted.

Monday, May 1*st*, 1876.

WILLIAM ADAMS, F.R.C.S., President, in the Chair.

THE ANNUAL ORATION was delivered by Mr. ERASMUS WILSON on

THE PROGRESS OF CUTANEOUS MEDICINE DURING THE PRESENT CENTURY,

A copy of which has been sent to each Fellow.

At the close of the oration a vote of thanks to the orator was proposed by the President and carried by acclamation.

The usual conversazione then took place ; the attendance was very large, and the arrangements gave general satisfaction.

Monday, October 16*th*, 1876.

WILLIAM ADAMS, F.R.C.S., President, in the Chair.

THE PRESIDENT delivered an address, of which the following is an abstract:

" Gentlemen,—On re-assembling at the commencement of another session of the Medical Society of London, now in the 104th year of its existence, allow me to offer to all the Fellows of the Society present my warmest congratulations. We meet, I trust, with renewed health and strength, for the work of the session, which I hope will not be less distinguished than its predecessors for the good work done, and the scientific character of the contributions which the Fellows are prepared to make ; and I feel confident that

all its proceedings will be conducted with the same good feeling, and courteous spirit, which have always characterised our discussions.

In the natural course of events, we can hardly hope to re-assemble year after year without some diminution in our ranks, caused by the unsparing hand of time; but this year we have especially to regret the loss of one who recently filled the Presidential chair, and who, by his learning, courtesy, and amiability, had endeared himself to all the Fellows of the Society.

In the death of Mr. De Méric we all find the loss of a mutual friend, one in whose judgment we placed the utmost confidence, and to whose observations on any subject under discussion we were in the habit of listening with equal pleasure, and profit. His natural shrewdness and quick perception, coupled with his intimate acquaintance with the general literature of the profession, enabled him readily to grasp the leading points in any debate, and to place it before the Society in a clear and logical manner. Mr. De Méric had been for twenty-six years a Fellow of this Society, and died on the 29th of August last.

In the death of Dr. Sibson, the Medical Society has also sustained the loss of another of its more prominent members. Dr. Sibson had been for twenty-seven years a fellow of this Society, and had filled the various offices of Councillor, Vice-President, and President. He was always one of the hard-working members of our profession, and in addition to his scientific labours devoted a great deal of attention to medical politics, and medical reform, always seeking to advance the best interests of the profession.

Dr. Sibson died suddenly at Geneva, whilst on his autumn tour, on the 7th September last, it is supposed from heart disease.

Mr. Fred. Disting Tothill was taken from us by death, on the 29th June last. Mr. Tothill had been thirty-three years a Fellow of the Society, and was engaged in the busy life of practice in the West-end of London. Of late years his avocations allowed him but little time to attend the ordinary business of this Society, in which he had formerly taken much interest.

We now pass to the more cheerful side of the picture, and I hope we may all be able to give one another some account of an agreeable, and sufficiently long holiday, taken during the medical recess.

When the invitation from America came to this Society through Professor Gross, as President of the Centennial medical commission, inviting it to send some of its members as delegates to represent it

at the Medical Congress, your surgical secretary, Mr. Davy, and myself agreed to offer our services to the council to represent the Society in the capacity of delegates; and one member of the council, Dr. Lauder Brunton, also expressed his willingness to unite with us in representing the Society at the Congress. Our services were accepted by the council, by whose direction our appointment was properly notified in America; and on our arrival we found our medical brethren in Philadelphia prepared to give us a cordial welcome, and to bestow upon us a more than full share of the official honours associated with the working of the Congress.

To me, personally, compliments were paid which, I need hardly say, were conferred upon me, because I had the honour of representing the Medical Society of London as your President.

On my arrival in Philadelphia, two days before the meeting of Congress, I found my writing-table not only loaded with private invitations to dinners, evening receptions, and suppers, such as Americans alone know how to give, but professional obligations of the highest importance were thrust upon me.

The meetings of the International Medical Congress were continued daily throughout the week, (from the 4th to the 9th of September), it was assembled in Philadelphia, and the scientific, and professional work, accomplished by the nine different sections into which the Congress was divided, was of the highest possible character, as will be seen when the volume of its proceedings, now being published, reaches this country.

It would be impossible for me here to enter into any general description of these various institutions, but I would refer those interested in the subject to the excellent account of the "American Medical Institutions," and "Observations on Medical Education and Surgery in America," published by Mr. Erichsen in the 'Lancet' of 21st November, 1874, shortly after his return from a prolonged visit to the American continent.

Amongst the operations of more than ordinary interest at the hospital was one of excision of the hip-joint, performed by Professor Sayre of New York. The patient was a little boy about ten years of age, who had been the subject of hip-joint disease for two years or more. Suppuration had existed for many months, and a little discharge was still issuing from one fistulous opening. The region of the hip-joint was much swollen, and the tissues infiltrated.

Professor Lister and myself were both requested to give our

opinion as to the advisability of the operation, and concurred in recommending excision, which Dr. Sayre performed. The joint was at once reached by a semilunar incision, and, after separating the periosteum from the neck, the head of the bone, which was still in the acetabulum, was detached *in sitû* by cutting through the neck with a strong knife. No saw was used, nor was the head of the bone turned out of the socket previous to its separation. The separated head was with a little trouble removed from the acetabulum, which was then found to be in a carious condition, and its roughened surface was removed with the gouge. The head of the bone was also partly destroyed by caries, so that our opinion as to the advisability of the operation was fully justified by the condition of the bone.

The method of treating the wound, and the apparatus used after the operation, are both worthy of being mentioned. The operation was not performed according to the antiseptic method of Lister, but, as an antiseptic dressing, compound tincture of benzoine was poured into the wound from a bottle, and the wound was then plugged with carbolised oakum. The child was then placed in a kind of wire framework cradle, adapted in shape and size to the head, trunk, and legs. The body and both legs having been bandaged in this cradle, an aperture, of course, being left for dressing the wound, the child was allowed to recover from the chloroform, which Dr. Sayre always uses in children, in preference to ether, the anæsthetic generally employed in America. The little fellow made no complaint of pain, and, in his wirework frame, was readily removed from the operating-table, and Dr. Sayre observed how easily he could be moved from place to place, and taken out into the open air, instead of being confined to bed with a splint, in the ordinary way practised in England. The case was doing well when I left America.

In the College of Physicians in Philadelphia were held some of our committee meetings, and in this institution there exists a very valuable, though not large, pathological museum.

In the Jefferson Medical College, the principal school for medical education in Philadelphia, is a large and valuable museum, and the lectures delivered by Professor Pancoast and others attract classes far greater than those assembled in our English schools.

On leaving Philadelphia I next visited Washington, a magnificent city, and the seat of government. The Capitol, as the Government House is called, is one of the finest buildings in the world, constructed throughout of the purest marble.

In a medical point of view, the greatest attraction at Washington is the large and well-arranged museum, which may be called the museum of the American war, containing illustrations of various wounds and injuries inflicted during the campaigns of the prolonged American struggle.

The recollection of a very agreeable visit to Washington is associated with the name of one of its most distinguished physicians, Dr. Tonor, whose guest I was for a few days, and through whose kindness I was enabled to visit the medical, and various other institutions in this great city.

American surgeons are good anatomists, and dexterous operators. There seems to be a mechanical genius in the American people, and the ingenuity of American inventions for surgical appliances is universally acknowledged.

In practical surgery we know there is much need of mechanical skill and ingenuity, both for inventive purposes, and in the adaptation and application of existing instruments, and this is certainly displayed in a remarkable manner by American surgeons.

To American surgeons we are also much indebted for their originality in several operations on deformed limbs, and anchylosed joints, which they have successfully treated by dividing the bones, either by open wound, or more or less subcutaneous methods. In this class of operations, amongst the earliest were those performed by Professors Brainhard of Chicago, Pancoast, and Gross, of Philadelphia.

At the meeting of the Congress, on the 8th of September, I read a paper "On the Subcutaneous Division of the Neck of the Thigh-bone," and the strictly subcutaneous method of performing these operations is now attracting much attention in America.

During the time not professionally employed, being desirous of visiting one of the western cities of the United States, and also of doing something more than it was possible to accomplish in England, *i. e.* to go a thousand miles in a train without stopping, we therefore went direct from New York *viâ* the Alleghanny Mountains and Pittsburg, to Chicago. The journey should have been accomplished in thirty-six hours, but the breakdown of a goods' train in front of us—not a very unusual occurrence in America—detained us five hours longer.

From Chicago, wending our way in a north-easterly direction, towards Canada, we travelled by the Michigan Central and Great

Western Railway to Niagara Falls, a journey of about twenty hours, taking up our quarters at Clifton House Hotel, on the Canada side, which I much prefer to the American, as presenting the finest view of these magnificent falls.

My next journey was crossing Lake Ontario to Toronto, and thence to Montreal, occupying altogther two days and a night.

The next day I re-entered American territory, and proceeded to Albany, the capital of the State of New York.

From Albany I took the steamer down the Hudson River to New York, and having had delightfully fine weather through the whole of the journey I have narrated, the same good fortune still remained for this delightful river trip. The scenery of the Hudson much resembles that of the Rhine, but without the picturesque ruins of ancient castles of historical interest, which lend additional attractions to that charming river.

From New York I proceeded to Philadelphia, acclimatized and strengthened for the professional work of the Congress. The treatment of the Philadelphia doctors, however, was so decidedly of a tonic character, that we hardly required the preparatory strengthening which the old antiphlogistic school no doubt suggested to our Scotch friend. Of our professional work at the Congress in Philadelphia, I have already given you a description.

I ought not to omit all mention of the passage out and home, as this is always in England looked upon as the most formidable obstacle to an American trip, and, not being more than a moderately good sailor, I regarded it as the only unpleasant drawback; however, Neptune was extremely kind to us on our passage out in "The Scythia," one of the finest of the Cunard vessels, in which we left Liverpool on the 5th August, and landed in New York on the 15th August, after a most delightful passage, in which one might almost realise the truth of our worthy Captain Hain's expression that the Atlantic is only a mill-pond, and the passage a ferry, *i.e.* in the special Cunard track.

We carried 270 cabin passengers, 98 steerage passengers, and 160 officers, crew, and servants, 528 persons in all, quite a village population, and our time was pleasantly passed with varied amusements, such as ship billiards, quoits, shuffles, &c., and in the evening the sailors' games, such as cock-fighting, bear-baiting, &c., afforded much entertainment. The Irish team for the boat race in Philadelphia, who were amongst the passengers, were regularly

exercised twice a day at the fire-engine pumps, and sometimes indulged in races. Later in the evening music reigned supreme, a set concert being given on one occasion, but popular songs and national airs were nightly continued until the order "all lights out" was given.

We made our homeward passage in "The Russia," a smaller vessel, but an old Cunard favourite, under the command of Captain Cook, who had but a small number of saloon passengers, only fifty-three; and no steerage passengers are carried by this boat. We left New York on Wednesday, the 20th September, and did not arrive at Liverpool till the early morning of Monday, the 2nd October; an unusually long passage, caused by the heavy gales and head winds encountered—unfortunate for an indifferent sailor—but still, with the exception of a few days, I thoroughly enjoyed the voyage, and the cheerful and convivial society of the gentlemen on board, amongst whom Mr. Otis, of Boston, and my friend Dr. Jolliffe Tufnell, of Dublin, conspicuously shone.

From what I have said it will be seen that our visit to America—at least for myself, and I believe I may speak in the same terms for the other delegates—was one of unmixed pleasure and gratification, to which our American friends did their utmost to contribute, and I have no doubt that any member of our profession crossing the Atlantic would be received with as hearty and cordial a welcome."

At the conclusion it was proposed by Dr. Routh, seconded by Mr. John Gay, and carried unanimously:

That Mr. William Adams be requested to publish his excellent address for the perusal of the Fellows generally.

Monday, October 23rd, 1876.

William Adams, F.R.C.S., President, in the Chair.

CROUP AND DIPHTHERIA—A CONTRAST.

Dr. Sansom related two cases which were treated at the North Eastern Hospital for Children; they occurred at the same time, and thus afforded an unusual opportunity of observing and contrasting the phases of the disease, (or diseases).

Case 1.—*Tracheal croup; threatened death from apnœa; tracheotomy; trachea choked with false membrane; recovery.*—Emily D—, æt. 3½, well-developed, and well-nourished, was attacked with symptoms of sore throat, with hoarseness, cough, and fretfulness, August 7th, 1876. Brought to the hospital on August 9th. She showed the signs of tracheal croup; there was increasing cyanosis and extreme distress, but no marked asthenia, and no false membrane was visible in the fauces. The urgency of the symptoms rapidly increased, and Dr. Sansom determined on the operation of tracheotomy, which was performed by Mr. Needham, the House-Surgeon, during the same afternoon. There was immediate relief. Sodium sulpho-carbolate in ten-grain doses was administered three times a day. On August 12th the child's life was in great jeopardy on account of the blocking of the trachea by masses of false membrane; like difficulties occurred during the succeeding four days, but were surmounted, thanks to the vigilant attention of Mr. Needham, who personally cleared the tube and removed the obstructing membranes. To further the detachment of the latter a ten per cent. hot solution of liq. potassæ, was "sprayed" through the tracheal tube, and this removal appeared very effectual; all the time the inspired air was warmed by flannels wrung out in hot water.

Subequent to the 15th the internal therapeutic treatment was by carbonate of ammonia (gr. iij), sp. chloroformi (♏v), vinum ipecac. (♏iv), glycerin (ʒj), aqua ad ʒss, 4tis quâque hora. From the 17th there was progressive amendment, and on September 8th the child was quite well.

Case 2.—*Pharyngo-laryngeal diphtheria; albuminuria; tracheotomy; appearance of diphtheritic membranes on wounded surfaces; sloughing; profound adynamia; death.*—Sarah E—, æt. 4½, thin and sickly, began to suffer sore throat on August 13th; both father and mother had soreness of the throat at the same time. Breathing had become progressively difficult, and the child was admitted under Dr. Cayley, on August 15th. White patches were observed on the right tonsil, and in the pharynx, and there was great obstruction to inspiration. Pyrexia, and great feebleness; urine sp. gr. 1015, loaded with albumen. Dyspnœa being urgent tracheotomy was performed under chloroform, the result being immediate relief. Sodium sulpho-carbolate in ten-grain doses administered every four hours. On August 17th the edges of the

wound were observed to be covered by diphtheritic false membrane; as also was an abrasion upon the lip. From this time sloughing proceeded, and the child's condition was one of extreme prostration. On the 19th a wound upon the ring finger of the right hand was observed to be covered by false membrane; from this wound ulceration extended with remarkable rapidity, involving the finger and part of the hand. During the following week there was a little amendment in the condition, but after August 26th the sloughing rapidly spread, extreme adynamia was manifest, pneumonia occurred in the bases of both lungs, and the child died during the night of the 31st. At the autopsy the larynx was found covered by false membrane, the tissues around the tracheal wound infiltrated, and a widely-spread sloughing of all the soft structures; organs of the body generally anæmic, but the kidneys in a condition of acute nephritis, and the lungs showing widely diffused broncho-pneumonia.

Dr. SEMPLE expressed his satisfaction that, in reference to the question of croup and diphtheria, we now at least know the points of discussion. It was essential above all things to define the meaning of the words we used, and the word "croup" had hitherto been made to include all cases in which there was stridulous breathing in children. A mother brought her child to a medical man, and said that it had the "croup," merely meaning that there was a rough breathing, perhaps from cutting a tooth, or a like cause. The scientific use of the word croup began with Home in Scotland, and Cheyne in England, both of whom described a disease characterised by the presence of false membrane in the windpipe; but, it was quite evident that both these authors included in their descriptions cases in which there was no false membrane. Afterwards Bretonneau came upon the scene, and comparing his own clinical experiences with the cases recorded by Home, he came to the conclusion that the disease with false membrane described by Home was exactly the same as that which he proposed to designate as "diphthérite." There could not be the smallest doubt that the "croup" of Home was the same as the "diphthérite" of Bretonneau, because Bretonneau said so himself in every part of his memoirs. All the French physicians, from the time of Bretonneau to the present day, regard croup, (or "vrai croup," as they call it, to distinguish it from laryngismus stridulus), as synonymous with diphthérite. Most of the Italian physicians who have written upon the subject, especially those who have studied a most serious and

extensive epidemic of late years in Florence, also use the words as synonymous. With regard to the German medical writers, it is true that Virchow, in his 'General Pathology,' draws some distinctions between croup and diphtheritis, but then he uses the words in a totally different sense to that in which they were employed by Bretonneau, and applies them to such diseases as dysentery, typhoid fever, metritis, and cholera. These views of Virchow were merely of an abstract and hypothetical nature, but the German writers who specially treated of the affections of the respiratory passages have regarded croup (with false membrane) and diphtheritis as exactly the same disease, or, at least, only differing in accidental and local characters. In proof of this position Dr. Semple would refer Dr. Sansom to the treatises of Bamberger in Virchow's own 'Cyclopædia,' of Oertel in 'Ziemssen's Dictionary,' of Huetet, and of Stoerck, the Professor of Laryngoscopy in Vienna. Coming back to Bretonneau, then, that writer laid it down as a rule that when there was a false membrane in the windpipe he called the disease "diphthérite" (from διφθερα, a membrane), and excluded from his category all cases in which there was no false membrane. Guided by this rule, Dr. Semple regarded both of Dr. Sansom's cases to be diphtheria, although they differed in some features of a subordinate character. One point was that in the case called by Dr. Sansom "croup," there were no false membranes on the tonsils and soft palate; but he would remind Dr. Sansom that, although Bretonneau laid it down as a rule that the tonsils and soft palate were so affected in diphthérite, yet he had himself pointed out exceptions to it. In fifty-five cases which Bretonneau had examined it was found that in one there was no false membrane either on the tonsils, or any part of the pharynx; and, in the cases examined during the Italian epidemic, it was found that in a certain small proportion the false membranes originated in the trachea, without any previous affection of the fauces. Dr. Sansom had expressed his unwillingness to answer the questions lately proposed on the subject of croup and diphtheria by the Sub-Committee of the Council of the Royal Medical and Chirurgical Society, on the ground that in their definitions of croup they regard the presence of false membrane on the tonsils as essential to the description. But, Dr. Semple ventured to remind Dr. Sansom that no such statement is made in the printed questions. The question, however, is—Are there two distinct diseases producing the same false membrane?

Dr. Rogers proposed, Dr. Crisp seconded, and it was carried, that the discussion on this subject should be adjourned until the next meeting.

Mr. Maunder exhibited three cases of

SUBCUTANEOUS OSTEOTOMY OF THE FEMUR BY A CHISEL.

He called attention to his having read a paper elsewhere on this subject, and showed four cases. He now proposed to show three more patients, in order that the profession might know all that he had done. He had been led to perform this operation from the many failures to correct deformity that he had made. The result of strumous hip-joint disease by more simple methods, such as tenotomy, forcible extension under chloroform, prolonged extension by weights, and St. Thomas' splint. In one instance he had in addition divided the neck of the femur with a saw subcutaneously, and still the patient had not benefited. The idea of dividing the bone below the lesser trochanter occurred to him, and to do this he had used a carver's "cold chisel" three eighths of an inch in width. The patients shown were of the respective ages 16, 21, and 24 years, and in each case extensive lordosis had existed, but was no longer present. In one case the thigh had been fixed at an angle of 118 degrees. The extremities were now parallel, and the patient could walk sufficiently as to reject a high-heel boot. In the other cases the thigh was fixed at right angles to the line of the body. The patients could both walk well. Six of the cases he had shown had been operated on to correct deformity, and one to correct a mal-united fracture. Mr. Maunder thought that the success shown in the use of the chisel could not fail to recommend itself to the profession. Of his seven cases, two of the earlier had suppurated slightly, but this could be prevented in future. Five of the cases healed primarily without any pus being secreted, and the patients got about from six to eight weeks after being operated on.

Photographs showing the condition of the patients before and after operation were exhibited.

Mr. Golding Bird stated that he had twice cut through the femur; in one instance with the saw, and in the other with the chisel. He was forty minutes dividing the bone with the saw. He much preferred the chisel.

Mr. Annandale had not divided the neck of the femur, but he had divided its shaft for knock-knee, also the shaft of the humerus for deformity. He preferred antiseptics with a free wound in place of subcutaneous osteotomy. Subcutaneously it was impossible to remove a wedge-shaped piece of bone. He considered that the chisel would replace the saw. He narrated Professor Lister's double case of knock-knee operated on successfully, and his own case of removal of the articular surfaces of the os calcis, and astragalus, by means of the chisel, thus avoiding the necessity for Syme's operation.

Mr. Adams mentioned that the region below the trochanters had been selected by American surgeons and by Mr. Gant prior to Mr. Maunder. Lordosis is in many cases due to adapted growth, and in his opinion was permanent. To gain motion in the thigh the bone must be sawn through completely, and not broken. Mr. Adams preferred the subcutaneous to antiseptic surgery, with a free wound.

Mr. Napier spoke very favorably of the drill as a mechanical means of effecting division of bone.

Mr. Davy had used the drill successfully in dividing the femur. He would be sorry for surgeons to pin their faith singly on saw, chisel, or drill. They were all useful, and it behoved the surgeon to carefully adapt the suitable instrument to the suitable case.

Mr. Hunt, of New Jersey, coincided with Mr. Davy, and mentioned how much attention division of bone was attracting in America. He gracefully complimented the delegates for their surgical labours at Philadelphia.

Monday, October 30th, 1876.

William Adams, F.R.C.S., President, in the Chair.

Dr. Rogers opened the adjourned discussion on

CROUP AND DIPHTHERIA,

and commenced by drawing the attention of the Fellows to a paper he had read before the Society some eighteen years ago on diphthé-

rite, and its distinction from croup with laryngeal membranous exudation. An epidemic of diphthérite having occurred in France, he had crossed over in order to study the disease, and from what he learnt there, and from his subsequent experience derived when the malady had travelled over to this country, he came to the conclusion that there are two distinct, though allied, diseases with a membranous exudation of similar character not distinguishable by a microscopical examination: one purely inflammatory, sthenic, the membrane being formed in the trachea and bronchi, non-putrescent, and non-contagious, called by us croup; the other characterised by membranous exudation, formed principally on the tonsils, soft palate, and pharynx, in its nature epidemic and contagious, spreading in families, and frequently attacking, fatally, nurses, and physicians in attendance. The first he regards as allied to a pneumonia pure and simple, from variation in temperature alone. The second as pneumonia, caused by a special poison, the petechiæ and gastro-intestinal symptoms making it too evident to us that it is a blood disease.

Dr. Crisp said he thought in this discussion some important facts had been omitted that should be brought more prominently before the Society. He was at a loss to imagine how the two diseases could be confounded, as they had scarcely two features in common. On looking at the weekly return of the Registrar-General the number of cases of diphtheria was reported, but nothing was said about croup, although it was a more fatal disease* than diphtheria, more fatal as regards the death-rate, and infinitely more fatal as regards the number attacked. Probably in croup one in three or four attacked succumbed to the disease, whilst in diphtheria, in this country, not more than one in thirty of those affected died. This was abundantly shown in the reports of the epidemic of diphtheria in this country. Again, an important difference existed as regards age; of 60,000 fatal cases of diphtheria about one half were over five years of age, whilst in the same number of cases of croup the great proportion were under two. Diphtheria was a highly contagious disease, and he knew of several cases where medical men had taken the disease from their patients, and some of them had died. But, who ever heard of a medical man affected with

* In the Registrar-General's returns, 1869, among fatal diseases, croup stands No. 26, diphtheria 37, and at the present time the difference would, perhaps, be the same.

croup by a croupal child? Some who had written and spoken on diphtheria appeared to assume that the croupal complication was very common; but, probably, it did not exist in one out of thirty cases, or more. It is *accidental*, not *essential*. He had seen two patients that day whose cases, he thought, afforded a practical illustration of the non-identity of the two diseases. One, a middle-aged lady, who had been travelling with her son and husband in Germany; they stopped at a first-rate hotel, where the water-closets were so neglected that the smell was scarcely bearable. The son was seized with diphtheria, and died in nine days, apparently from exhaustion from the effect of the poison; there was no laryngeal, or tracheal complication. The mother, who had nursed her son assiduously, took the disease, and after a hard struggle for life was brought to England. In addition to the leathery throat, she was supposed to have slight deposit in the upper part of the larynx, but she has likewise partial loss of voice, paralysis of the muscles of deglutition, slight loss of muscular power, and tingling in the extremities. The other case, seen on his way to the Society, being one of croup, (cynanche trachealis), in a child aged twelve months, no unnatural appearance being present about the palate or tonsils, but the internal mischief in the large air-tube was unmistakeable. He would ask, what resemblance had these two cases one to the other? Dr. Crisp, in conclusion, begged to express his surprise that croup was still included by the Registrar-General among zymotic diseases, and he was of opinion that the sooner it was moved from this category the better.

Dr. Semple apologised for speaking again in the debate. He rose, however, to correct some expressions and supply a few omissions in his former remarks. He believed that in the first case narrated by Dr. Sansom the recovery of the patient was clearly due to the attention shown by him, and his house-surgeon, to whom every praise should be accorded. He had intended, when speaking of Virchow, to imply nothing disrespectful towards that great pathologist, but to express his opinion that in his work on 'Pathologie und Therapie' the words croup and diphtheria were used in so extended a sense, including dysentery, cholera, typhoid, &c., that it was impossible to accept them in a practical discussion like the present on an affection avowedly situated in some part of the respiratory organs. In the list of questions relating to croup and diphtheria recently sent out by a sub-committee of the Royal

Medical and Chirurgical Society, (a copy of which he submitted), it was stated that no case was to be regarded as croup unless a false membrane were found somewhere, either during life or after death. No statement was made, however, as Dr. Sansom seemed to suppose, that there must necessarily be a false membrane visible on the fauces; in fact, it was admitted by all authors of experience that in a certain number of cases of tracheal diphtheria there was no membrane found except in the trachea. He still believed that Dr. Sansom's cases were both instances of diphtheria, differing in some subordinate features, but agreeing in the essential fact of the presence of a false membrane in the windpipe. He saw no more difference between them than there might be between a sthenic and an asthenic case of pleurisy, false membrane being the characteristic feature in both. In the sense now applied to the words used, false membrane being found in the trachea, there was no difference whatever between croup and diphtheria. He was confirmed in this opinion by Bretonneau, and the whole of the French physicians.

Dr. Wynn Williams believed, with Dr. Crisp, that the two diseases were totally different. He regarded croup as an acute inflammatory disease, requiring antiphlogistic remedies, while diphtheria, from the very first, called for the very opposite kind of treatment; stimulants and support of every description. In true croup the exudation is almost always out of sight, while in diphtheria it is readily observable on the tonsils, fauces. One very marked difference exists, which had not been alluded to—the peculiar odour emanating from a diphtheritic throat, once smelt never to be forgotten, which was not present in croup. The sequelæ of diphtheria differed also widely from those of croup.

Dr. Frederick Simms related several cases of croup which he had met with, and called attention to particular points which convinced him that the disease differed totally from diphtheria, which did not exist till of late years.

Dr. Edmunds differed from Dr. Crisp in his opinion that there were out of every hundred cases of diphtheria very few that terminated fatally; the whole fallacy arising from the fact that some practitioners included under the term diphtheria cases which were only common, inflammatory, sore throat. There were three distinct diseases:—1st. True inflammatory croup, a disease essentially of childhood, sporadic and non-contagious in character, the membranes rarely extending out of the larynx and trachea. The disease

was an acute and continuous inflammatory one, which killed by apnœa and clot in the heart, and was not followed by paralytic affection. 2nd. There was diphtheria in which prostration of strength was marked from the commencement of the disease; a membrane of softer and more mucoid character commonly commenced about the velum and throat. The membrane might extend into the larynx, and pass through into the bronchi, in which case all the symptoms of an adynamic croup would be present. But this diphtheritic croup arose out of gross insanitary surroundings; it was endemic, and under certain conditions epidemic; it carried off several children out of a family, and often affected other persons by contagion who came into close contact with the breath of the patient. It was a disease of all ages, and was very fatal. 3rd. There was the common inflammatory sore throat, in which a dusky and turgid shining condition of the velum was seen, with local abrasions and white patches about the tonsils. Under some circumstances, as of persons sleeping together, this disease might be infectious, and no doubt it was also associated with insanitary conditions; but it was quite a different disease from diphtheria, and was but rarely fatal. Generally it might be traced to a chill on leaving badly ventilated rooms.

Dr. Routh said that from the definitions given by the speakers, by the Registrar-General, and at the Royal Medical and Chirurgical Society, it would appear that they were talking of different diseases, although specified here as croup and diphtheria. Dr. Semple took his cue from Bretonneau; he would speak from his English practice. The confusion of terms, he thought, would be removed if he considered three separate diseases apart from the scarlet fever and the cynanche tonsillaris, and in these three it would be right to premise that you might have exudation in the throat, and that the membrane in all had similar microscopical characters:—1st. Croup was an acute disease attacking healthy children suddenly, generally when exposed to the cold east wind; not contagious, nor capable of producing puerperal fever by contagion, running its course rapidly, and causing the secretion of a fibrinous membrane in the trachea and upper part of larynx, sometimes extending to the bronchi, and generally curable if taken in time. The cough was peculiar, ringing and metallic, and often shreds, indeed casts of the part in which the exudation had occurred, were coughed up. Generally the cases were solitary, or

if more than one in a family were attacked it was merely from similar exposure to cold, it was more common in particular families, and recurred in infancy very rarely, and then it was only the result of exposure; albumen was present in the urine. The two other diseases were diphtheria and erysipelatous sore throat, as it had been called. Both were highly contagious, capable of producing puerperal fever in lying-in women, not restricted to infancy, cold seasons, places, or families; in these respects they differed. Diphtheria was very fatal. He would not say the mortality was 1 in 50, but 7 in 10. 2nd. There was exudation beginning above the trachea and generally soft palate, occasionally passing downwards into the bronchi. 3rd. It might affect any mucous surface, nasal, intestinal, vaginal, &c., which croup never did. 4th. It was very asthenic. 5th. Albuminuria always present; and 6th. Occasionally followed by paralysis of muscles, and with peculiarly offensive breath. The contagious or erysipelatous sore throat was well known to the Society; papers by Dr. Crisp, Dr. Farquharson, Dr. Pearson, and himself having been read before the Fellows:—1. Diphtheritic spots might be seen on the soft palate, but they were sparse and limited, rarely amounting to any quantity, the throat being intensely red. 2. It was not very fatal, although occasionally it ran a rapid course, killing in a day. 3rd. It seemed to be present synchronously.

Dr. Leonard Sedgwick related, as a contribution to the value of statistics, his experience in an investigation which it was his business to make some years ago in a northern county concerning this present subject. He circulated among a considerable number of practitioners a series of questions as to the nature, treatment, frequency, and mortality of diphtheria. The replies were divisible into two classes: one in which the cases were few, and the mortality great, another in which the cases were very numerous, and the mortality almost nil. On personal inquiry he found that the first class was made up of cases of undoubted diphtheria, and the second of cases of simple sore throat, usually accompanied with follicular inflammation.

Mr. Maunder said he had listened to the discussion with much pleasure, and he was strongly impressed with the belief that croup and diphtheria were distinct diseases. Tracheotomy had been performed in one case of Dr. Sansom's, and he congratulated the operator on the result. In his opinion, tracheotomy for obstructive and acute disease must not be performed slowly, with the expectation that bleeding will cease, but, on the contrary, quickly, because as

soon as the windpipe is opened, and respiration re-established, venous hæmorrhage will naturally stop. Also, it would be a great boon if the tracheotomy tube could be dispensed with; and in a recent case, where he had removed a foreign body from the left bronchus, he had found that the aperture in the trachea was kept well open for a short period by a single suture, inserted on either side, so as to fasten the margin of the cut cartilages to the edge of the wound in the soft parts.

Monday, November 6th, 1876.

William Adams, F.R.C.S., President, in the Chair.

The third General Meeting of the year took place.

Mr. Richard Davy read a paper on

DEGENERATIVE CYSTS IN MUSCLES.

During the Winter Session, 1876, in our dissecting-room was an old subject, whose voluntary muscles presented features of interest. Male, æt. 82, emaciated, had died in the St. Marylebone Workhouse of old age, and diarrhœa. His muscles were studded in about fifty places by cysts, resembling wheat corns, or grains of rice; in all cases separately, and voluntary fibres alone were intruded on. Each cyst was placed with its long axis parallel to the muscular plane. An artery could generally be traced to one end of the elongated cyst. The deltoid, teres major, biceps, rhomboideus major, serratus magnus, flexor carpi radialis, extensor communis digitorum pedis, flexor longus pollicis pedis, and gastrocnemii muscles may be quoted as sites. These cysts, though very similar in size, varied much in consistency; some being caseous and soft, others hard and cretaceous. A delicate fibrous capsule enveloped the contents. (Specimens shown.)

The microscope showed the contents to consist of large, epithelial-like scales undergoing fatty degeneration, many free granules of fat, and much amorphous grit. Chemically, a slight reaction of

lime-salts resulted. On carefully scraping the cyst-walls of many, a hooklet (drawing exhibited) was demonstrated.

While engaged in the study of these cysts, a student brought under my notice a cretaceous nodule (exactly similar in shape and size to these) which he had removed from the sartorius muscle of an old man in St. Bartholomew's Hospital dissecting-room. This nodule was quite bony in consistence. On section it turned out to be less hard in the centre, and the microscope showed epithelial *débris*, with a marked tendency to laminate at the circumference. (Nodule exhibited.)

As I could not find any of these degenerate cysts in the museum of the College of Surgeons, I handed over some of these parasitic capsules to Professor Cobbold, who kindly writes as follows:

"Mr. Richard Davy having communicated to me the facts of his interesting observations, I wish to state that although the literature of helminthology is by no means destitute of similar records, yet that up to the present time no adequate explanation has been offered as to the full value and practical significance of the pathological data, if such they may be called.

"The prevalence of cysticerci in the human body is not considerable; nevertheless, probably not fewer than 150 instances are on record of their occurrence in the muscles, and areolar tissue. At least another 100 cases have been published where they have been found in the brain, and eye, and perhaps as many as twenty notices have been made of their occurrence in the heart, and viscera of the trunk generally.

"Among the more remarkable instances of multiple cysticerci are those recorded by M. Delore (1864) and Dr. Giacomini (1874). In M. Delore's case about 2000 were obtained *post mortem*. Dr. Knox published an instance similar to Mr. Davy's in the 'Lancet' (1838); and in the year 1857 Dr. Hodges, of Boston, U. S., published a case where the cysts, which in size he compared to rice-grains and coffee-beans, were felt subcutaneously.

"As regards animals, it is not so generally known as it ought to be, how common these parasites are in most kinds of flesh sold as food. Thus, the 'Montpelier Medical Journal' for last September contains a paper by MM. Masse and Ponquier, in which the authors allege that these parasites do not occur in mutton. To say nothing of these sources of evidence, I may state that on five separate

occasions I have removed measle-cysts from joints of mutton that were brought to my own table.

"Into an explanation of the mode in which these parasites gain access to human and animal bearers I will not now enter; but I desire to add that numerous experiments and observations made by me during the last twenty years have led me to deduce the following conclusion, which I think will stand the test of future experience:—All measles, hydatids, and bladder worms, and also all sexually immature forms of other types of entozoa, present a more or less restricted period of vitality, at the expiration of which their life epoch (or rather biotome, as I prefer to call it) terminates by calcareous degeneration. In the case of cysticerci eight months is the probable limit."

The third instance shown was a gritty cyst removed from the iliacus muscle of an old woman now in the dissecting-room at Westminster. This cyst resembles exactly a grain of rice.

These three cases coming under observation in a year seem to prove that cysticerci in muscle are more common than suspected, and afford no evidence of any special symptoms during life.

Dr. Routh asked if all the patients came from the same workhouse, or if they were all workhouse people.

Dr. Lawson thought the cases interesting, but not extraordinary, and gave a history of the steps by which a tapeworm swallowed by a sheep or hog could at length be developed as such in the human intestine.

Mr. Davy replied briefly.

Dr. John Brunton then read a paper on

PELVIC HÆMATOMA.

After giving his reasons for preferring the expression "pelvic hæmatoma" to hæmatocele, in that the former was more comprehensive and included all the kinds of cases, he went on to describe shortly the various kinds; after which he said that he intended to deal only with the intra-peritoneal variety, of which his cases were examples.

Having given a narrative of three cases which had occurred in his practice during some sixteen years, he pointed out characteristics of the cases, one of which terminated fatally in four weeks after first attack.

He called attention to the suddenness of the onset of serious symptoms (though there had been some preliminary disturbance of the uterine functions), viz., the anæmia or bloodless appearance of the patient, accompanied with sudden pain, prostration, collapse, cold and clammy skin, perspiration, pulselessness, or extreme rapidity and feebleness of pulse, with great sickness and retching, all evidences of sudden hæmorrhage, which on inquiry was found to be internal and pelvic, as evidenced by the abdominal examination, showing dulness on percussion at its lowest part; by vaginal and rectal examinations giving their own characteristic signs, viz., altered position of the uterus, bulging swelling of a boggy nature, not fluctuant, in the roof of vagina, and found also per rectum, pressing on it, and causing difficulty of defecation, while the forward pressure on the bladder interfered with the micturition.

He mentioned the termination of the cases. Nature cured the first by causing an opening into the rectum, by which the blood was discharged. The second case, which terminated fatally, was examined post-mortem by Dr. Thompson, and though a very large quantity of blood was found, partly fluid, and coagulated in the pelvis, enough to kill, there were not the slightest traces of peritonitis or encysting, and, though a very careful examination of the parts was made, no trace of ruptured vessels could be found to show whence the blood came.

The third case is now well, having had two or more hæmorrhages, which were successfully combated by the oft-repeated internal administration of spirit of turpentine.

This led to the question whence came the blood. Dr. Brunton thought there were several sources; he obviously excluded hæmorrhages from rupture of uterus, tubal pregnancy, accidents of childbed and the like. The sources were most likely ovarian, tubal, blood regurgitating along the Fallopian tube, or a general oozing from the uterine tissues, or a rupture of some of the enlarged or varicose vessels in the broad ligaments.

Regarding treatment, *absolute rest* and as *few examinations* as possible were the most important points; maintain the strength, recruit the system, make new blood, relieve pain, and, if urgent symptoms arise, meet them. His experience of one case treated by turpentine was not much to go by, but the success of this remedy in other hæmorrhages certainly warranted a fair trial. So far it appeared successful.

Dr. Brunton thought such cases comparatively rare, necessitating the recumbent position in bed for some four or more weeks. As to prognosis he thought it very serious on account of the large internal hæmorrhage, and the severity of the symptoms.

Diagnosis he thought was simplified by the severity and suddenness of attack, and the acute inflammatory affections of the uterine appendages were eliminated by the absence of fever, and increase of temperature, in pelvic hæmatoma.

In all the cases there had been *no* increase of temperature worth recording; on one occasion in the fatal case 100·5 had been reached, but fell next day, and probably was due to some accidental cause.

Dr. Godson then moved, Dr. Rogers seconded, and it was carried, that the discussion be adjourned to this day week.

Monday, November 13th, 1876.

William Adams, F.R.C.S., President, in the Chair.

Dr. Crisp exhibited two preparations in relation to croup. The first was a piece of croupal membrane, two inches in length, and half an inch in width, expelled from the larynx of a child, three years old, affected with cynanche laryngea. The child had been ill three days when the membrane was expelled, and died on the day following, apparently from suffocation. In this case there was no exudation on the fauces, or on any part external to the glottis. Dr. Crisp reported that the case he alluded to at the meeting of the Society on the 30th ult. died the next day, but he was unable to obtain a post-mortem examination. In this case, too, there was no exudation outside the glottis, although the mechanical obstruction within the larynx and trachea was unmistakeable. The next specimen was the larynx, trachea, and fauces of a child, eighteen months old, that died of croup; here, also, there was no membranous deposit external to the glottis, although both the larynx and trachea were nearly filled with it (specimen shown). In these cases there was no resemblance in any particular to diphtheria, the disease was of a local nature; neither was there any exudation of membrane outside the air-tube. Dr. Crisp brought these cases before the

Society to show that these examples of croup bore no resemblance to diphtheria; for, whilst in the former the presence of exudation in the air-tubes was *essential*, the presence of membranous deposit in diphtheria was *accidental*. The membrane in the two diseases, it was true, presented but little difference microscopically, but it should be remembered, and it was a fact that was lost sight of during the late discussion, that whilst in croup the membrane was upon the mucous membrane, in diphtheria it not infrequently destroyed it, sometimes extending more into the muscular tissue, and between the interstices of the muscles. He had recently seen a case of this kind, which he examined after death.

The following letter was read by the President:

Philadelphia, U.S.;
Oct. 19*th*, 1876.

Dear Sir,

In accordance with your request at the meeting of the late International Medical Congress in this city, I write to inform you of the progress of the patient on whom I have performed your operation of subcutaneous division of the neck of the thigh bone. The patient was a child nine years old, with ankylosis of both hip-joints from hip disease. The case was one of those which you have designated as of the "bad strumous kind," and I therefore said to my assistants at the time that if the result should be unsatisfactory it must not be put to the account of your operation, as the case was not one of those for which you recommended its performance. The result has been, however, better than I hoped, and as far as the operation is concerned the patient is well, though, of course, she is still a very strumous child with chronic bone disease. The nature of the deformity you will see from the enclosed photograph; the patient could neither sit nor stand. Her limbs are now parallel, and of nearly the same length, and I see no reason to doubt that in a few weeks she will be able to use crutches. I operated first on the left side (September 21st), following strictly your method; there was no constitutional disturbance, and the little wound united by adhesion. On October 5th (just a fortnight ago) I operated on the right side, but here, as the neck of the bone seemed to have entirely disappeared, I followed Mr. Gant's modification of your operation,

and divided the shaft of the bone just below the trochanters. The puncture was necessarily made pretty close to an old sinus, which was still discharging, and on the third day these appear to have communicated superficially with each other; for several days a little pus came from the puncture, which now, however, seems to be closing. I applied at first a weight of 2 lbs., gradually increased to 6 lbs., and have kept the limb still supported with sand-bags. Neither operation was followed by more constitutional disturbance than often results from the simple administration of an anæsthetic when no operation is performed.

I expect to operate on another patient in a few weeks, and last Monday I assisted Dr. Ewing Mears, of this city, in subcutaneous division of the neck of the humerus for unreduced dislocation of long standing.

I enclose, as you desired, a memorandum of the history of Rhea Barton's operation and its modification, as far as I have been able to trace it.

I remain, dear Mr. Adams,
Very truly and respectfully,
JOHN ASHHURST, junr.

Mr. GANT said that this letter was of great interest, as opening up the question of the principles of the two operations originated by Mr. Adams and himself; there were a certain class of cases in which Mr. Adams' operation would always be more or less successful. He alluded especially to early strumous, and early rheumatic disease of the joint; he used the expression "early" advisedly, as he doubted the efficacy of the operation when the disease was at all advanced. *If* Mr. Adams' operation could be performed it was undoubtedly the better, but there were cases of advanced strumous disease in which the neck was worn down almost to the shaft. A subcutaneous section of the neck *cannot* be made, for there is no neck to divide. In a case similar to this in December, 1872, Mr. Gant performed his operation with a tenotomy knife. He turned the muscles forward, introduced the knife down to the bone with a very small puncture, and with a small saw divided the bone just below the small trochanter; there was very little bleeding, the muscles returned to their places, a valvular opening only remaining. No pus formed, and the boy got up with a perfectly straight limb, on which he could stand well. An account of this case will be found in

the 'Lancet,' 21st December, 1872. There was another class of cases produced by rheumatism, where a quantity of new bone was thrown out around the femur. He thought it would be impossible to saw through such a mass, and even if it were possible, the result of the operation would not be satisfactory, while that in which the bone was divided below the small trochanter should be practicable, and in this case would well supplant Mr. Adams' operation. Mr. Maunder had of late (in July, 1875, first) used the chisel in place of the saw. He (Mr. Gant) did not think, however, it would answer in the end; there might be a small splinter of bone which would give rise to suppuration. Whether with this, or with the saw, there would probably be a certain number of unsuccessful results. He knew that in one case there had already been a death after the use of the chisel.

Mr. Maunder said that there had been five consecutive cases without a drop of suppuration; he therefore thought this conclusive. Mr. Gant had not performed his operation since the time of its report in the 'Lancet,' until his attention was drawn to it by hearing of the operation with the chisel. When he first used the chisel he had no idea that the saw had ever been employed in the same situation; had he been aware of it the probability is he would have used that instrument in place of the chisel.

Mr. Wm. Adams thought it only just to Mr. Maunder to state that he was unaware of the site for the operation having been chosen by Mr. Gant, until he (Mr. Adams) drew his attention to it.

Dr. Godson then opened the adjourned discussion on

PELVIC HÆMATOMA.

He said that pelvic hæmatocele was much more common than Dr. Brunton's paper would lead one to infer. At St. Bartholomew's Hospital during the last seven years 79 cases had been treated out of 1134 cases of the diseases of women. Dr. Brunton had stated that, where there had been a large intra-peritoneal effusion causing a distinct abdominal tumour, the uterus was pushed up very high. Dr. Godson thought that in those cases in which the uterus was forced up the blood was generally under the peritoneum. Deaths from pelvic hæmatocele were fortunately very rare, the effusion

generally being sudden and quickly arrested, probably by the pressure of the blood-tumour.

Dr. Rogers considered that pelvic hæmatocele was much more frequent than was formerly supposed, many cases having been mistaken for fibroids. He had seen this year four cases, in two of which the diagnosis was very doubtful, and was only agreed upon by a careful examination under chloroform. One case in hospital, which terminated fatally, had been mistaken for fibroid. He thought that a great many cases would get well of themselves if the patients were kept completely at rest. If operative proceedings were necessary he would advise tapping by the rectum.

Dr. Aveling approved of Dr. Brunton's nomenclature. He thought the term "hæmatoma" far preferable to the term "hæmatocele."

Dr. Routh considered that the author had too exclusively confined himself to those cases of very sudden hæmorrhage. The question had arisen in his mind whether, when a patient was seen suddenly bleeding internally, and the bleeding could not be arrested, it would not be justifiable to cut down direct, and try to find the source of the hæmorrhage. He thought that no case ought to be called hæmatocele unless the blood be encysted. With regard to treatment, in many cases rupture takes place per rectum, and all the patients do well. The vagina was not suitable for tapping, because of the air which was drawn up into it by the simple effort of expiration, which would pass through the opening made by the trochar. The sphincter ani kept the anus closed, so that the rectum was much safer to tap through.

Dr. Heywood Smith thought that the chief interest depended on the differential diagnosis, pelvic cellulitis being frequently mistaken for the affection under discussion; as a rule he considered it far better not to operate. He mentioned a case which was believed to be due to tubal pregnancy and rupture, in which decidual membrane was subsequently discharged.

Monday, November 20th, 1876.

WILLIAM ADAMS, F.R.C.S., President, in the Chair.

DR. LAWSON exhibited some micro-photographs of the blood-corpuscles, which had been shown at the Philadelphia Exhibition by Dr. Woodward, of that city. Dr. Lawson stated that Prof. Hayen has been able relatively to enumerate the red and white corpuscles by means of these photographs. These experiments had been conducted with great care, the same preparations having been examined many times during four years.

Dr. HENRY DICK then read a paper on—

DIVISION OF URETHRAL STRICTURES BY CUTTING.

The author commenced by stating that in the present paper he would only touch on the practical points of treating strictures by division, as time would not permit the discussion of the pathological anatomy of strictures. He observed that he was not a great partisan of division of strictures. He considers gradual methodical dilatation by the metallic urethral bougie the best and safest treatment, but the bougie should only remain a short time (five minutes) in the urethra. He is opposed to the treatment of leaving an instrument twenty-four hours in the urethra. He says the urethral metallic bougie should imitate the shape of the urethra, and its length be so constructed that it would not go beyond the urethra, and enter the bladder.

The author exhibited to the Society his improved metallic explorator for the diagnosis of stricture. The shoulder at the head of the metallic explorator is rather abrupt, and the reason of this is because, in drawing back the explorator, deviation or slight tightening of the urethra can be detected.

The author exhibited a speculum which he uses for diagnosis of strictures near the orifice of the urethra.

But, there are some cases, in his opinion, where division is quired. People on active service in the colonies want to be

cured quickly, and avoid the risk of being troubled with retention of urine in a distant country, where good medical advice is scarce; or, in some cases, the stricture or strictures are so contracted that dilatation is almost impossible, or the stricture even dilated remains open only for a very short time, and retention of urine recurs at the slightest cold, or a little excess. In all such cases the author thinks division of the stricture is required. Other methods of treatment have been recommended for such cases, as splitting, potassa fusa, electric cautery.

The author opposes the method of splitting strictures, on the grounds—(1) that we do not tear parts in surgery when they can be cut; (2) we do not know what we tear; (3) the reaction and contraction after lacerated wounds is more severe than after incised wounds; (4) the local nervous system of the urethra will certainly be more injured, and therefore the patient will be more exposed to pyæmia.

He opposes cauterisation, on the grounds—(1) There is nothing to be destroyed, the constriction of the urethra is the result of want of material, it is contraction. (2) If the contraction is destroyed by potassa fusa, or the electric cautery, we shall have a new cicatricial tissue more troublesone than the previous stricture. (3) Cauterised strictures seen four to five years afterwards are the most troublesome to treat.

The author then came to the treatment of strictures by division. He divides this method into two proceedings—(1) the internal division, and (2) the external division. The second he subdivides again into (*a*) Syme's operation, (*b*) la boutonnière, and (*c*) his operation, or the subcutaneous division of strictures. The author calls the third his operation, as before he related his first case in the 'Medical Times and Gazette' in the year 1853, there is not a word mentioned in any book or printed matter on this operation.

The most frequently practised operation in modern time is the internal division of strictures. Numerous instruments have been invented to make the operation safe and successful, but the author thinks we have (1) to confide too much to mechanism in the cutting of strictures by this method, and the tyro surgeon will find great difficulty in using these instruments; they will be even dangerous in some hands if not used with the greatest caution. (2) We are never sure we are cutting on the exact spot, or have cut completely the *whole extension* of the stricture; and, if the cut is not a

deep and *long* one, the operation is a failure. The author practises internal division only in cases of stricture near the orifice of the urethra, which he does by a grooved dilator of his own invention, (exhibited to the Society), and a small tenotome. He exhibited also an instrument to the Society, called by him "sonde-tourniquet," which the author leaves for a short time in the urethra to arrest bleeding after the operation. External division may be performed (*a*) by Syme's operation, which the author condemns on the ground that the operation is a severe one, that parts are cut which have no connection with the stricture, the healing process is long, and therefore liable to danger from pyæmia, and after such a large wound recontraction of the divided parts is more to be feared. Only in traumatic strictures Syme's operation finds its indication. (*b*) La boutonnière is another method of operating on impassable strictures. But the author thinks in modern times surgery has better means to overcome impassable strictures; and if all means fail, then remains the subcutaneous puncture of the bladder in connection with the vacuum pump, as a last resource. (*c*) The subcutaneous division of strictures is an easy operation. The author exhibited the instruments he uses in the operation—(1) a grooved conductor, (2) a small tenotome for cutting strictures subcutaneously before the scrotum, and a long-necked tenotome for cutting strictures subcutaneously behind the scrotum. The author attributes the success of the subcutaneous operation to three causes—(1) The stricture is by this method always divided in its entire *length* and *depth;* (2) to the employment of the *bougie à bulbe*, which he exhibited to the Society, and by which dilatation is made of the divided parts; (3) carefully practised dilatation by the bougie à bulbe during two years after the operation. He thinks the greatest liability to recontraction exists during the first six months after the operation. He believes that strictures can be cured, and he is not of the opinion of a well-known surgeon who says, "once a stricture always a stricture." At the end of the paper the author drew the following conclusions:

1. A stricture can be cured by dividing it.

2. The safest and surest method is the subcutaneous incision, with few exceptions, in which other operations are indicated.

3. The cut should always be long and deep.

4. That two years' treatment is necessary to get a successful result of the operation.

Mr. Adams considered Dr. Dick's method a good one, and referred to a case published in the 'Transactions' of the Royal Medical and Chirurgical Society, 1864, in which an officer, under his own care, suffering from traumatic stricture was cured by this procedure.

Mr. Teevan had but slight experiences of this operation. Penile strictures of one ring might be so divided. He preferred internal urethrotomy followed by good dilatation. Otis' operation was objected to by patients, yet Otis is right in maintaining the dilated urethra to the limit of dilatation. He did not believe in the cure of stricture, but thought that the use of the bougie must be maintained. He narrated a case of stricture that had been removed by slight salivation, and mentioned that 700 or 800 cases should be seen before utilising statistical information.

Mr. Gant said that he should use Civiale's instrument for post-bulbous, Maissoneuve's instrument for anti-bulbous stricture, otherwise he preferred internal urethrotomy; afterwards he uses a conical distensor for the strictured portion, and keeps it in for twelve hours.

Mr. Bryant was disappointed at Dr. Dick's paper. In three cases he had used this method of subcutaneous urethrotomy; two were bulbar, and one penile. In two extravasation of urine occurred. Strictures must ever be divided into traumatic, and organic; the traumatic strictures will contract, and Syme's operation probably should be had recourse to. In organic strictures dilatation by metallic bougies answers well, inducing absorption by pressure. Where dilation fails, however, some operation must be selected, and he spoke decidedly in favour of that of Mr. Syme. He was not in love with internal urethrotomy, and stated that where the urethra is completely obstructed there is no operation that can be quoted as perfect.

Monday, November 27th, 1876.

William Adams, F.R.C.S., President, in the Chair.

Dr. Lichtenberg introduced a boy, aged 14, on whom he had performed excision of the right ankle-joint, and likewise removed

the greater part of the os calcis. The patient had been an inmate of the German Hospital, and had been suffering for some time from caries of the right ankle-joint. In February of last year excision of this joint was performed according to Professor von Langenbeck's method, viz., by making a longitudinal incision on the fibular side down to the malleolus, and removing then the articular surface of the fibula. A similar incision was then made on the inner side of the foot, to the lower end of which incision a semilunar one was made on the sententaculum tedi, and a considerable portion from the lower end of the tibia then removed. Both operations were done subperiosteally. After this the entire astragalus was taken out, revealing unfortunately the os calcis also implicated, and to such a degree that after being scraped by the sharp spoon or scoop, not much more than a mere shell remained of the same. Although the patient improved after this, a second operation had to be undertaken in July of the same year, the disease having spread on the fibula, and another inch of the same had to be taken off. Likewise, the same surface of the tibia was found in a very unhealthy condition, and the medullary part of the same was scooped out to the extent of one and a half inches. On the inner side the tibia had formed some attachments however. After this second operation the patient improved immensely, and in October the wound on both sides had entirely closed. In order to give the newly-formed joint a firmer hold, a plaster-of-Paris bandage was applied. In a short time, however, the patient's condition again altered for the worse, the bandage had to be removed, a fistula soon formed on the outer side, and the probe detected again diseased bone, apparently belonging to the os calcis. In February of this year, just a twelvemonth after the first operation, a long incision was made on the os calcis in the sole of the foot, the diseased parts thoroughly removed by means of the scoop, and the actual cautery afterwards applied. The recovery was even then a slow one, for the patient could not be discharged before August from the hospital, a small fistular opening still remaining, which, however, soon closed during his stay at the sea-side.

The author drew the attention of the Society principally to two points of interest, the first showing what Nature is able to accomplish under even the most trying circumstances, for by her help a new movable joint had been formed, and traces of a new internal malleolus could be perceived. With regard to the formation of a

new external malleolus, however, Nature seemed to have been less fortunate—a circumstance to which Professor Volkmann already alludes in his little pamphlet on "Excisions of the Joint."

The second point upon which the author principally laid great stress was that the surgeon should be very prompt in removing any diseased parts that might have been left behind, or that developed themselves again. The best way to accomplish this was generally by means of the scoop, and this should be used very freely if necessary. He thought that if each operation had followed the other more promptly in the foregoing case, he would have shortened the healing process very considerably. He was of opinion that it would generally be found necessary in the first instance to give the patient a mechanical support, which would keep part of the weight of the body off from the newly formed joint. This had been done in the present case, and it was doubtful whether in this particular instance the patient would ever be able entirely to dispense with it.

Lastly, the author stated that there was no doubt that excisions of the ankle-joint, undertaken on account of injury, produced a far better result in every respect than those undertaken on account of disease. Professor von Langenbeck, and Professor Volkmann, both fervent advocates for this operation when undertaken after injury, speak rather disparagingly of it when undertaken on account of caries. He, however, agreed with Mr. Hancock, the introducer of this operation in England twenty-five years ago, who, in speaking of this operation on account of disease, says, that "when excision of the ankle-joint is better understood, and the cases to which it is applied are more carefully selected, the prejudice with which it has hitherto been regarded will fade away, and it will be more generally adopted and take its proper position among the standard operations in surgery."

Mr. Maunder congratulated the author on the great success resulting from the operation. He had twice resorted to excision of the ankle-joint, one of the patients operated on having been brought by him before the Society. He thought there was great difficulty in coming to a diagnosis as to indicate the operation to be performed. In gelatinous disease of the joint there was generally a peculiarly ring-like swelling, which was a useful guide.

Mr. Royes Bell had seen two cases of disease of the ankle-joint where excision of the astragalus had been performed by Mr. John

Wood; in these Esmarch's bandage had been used, which he considered very important. The drainage tube had also proved very useful. In Dr. Lichtenberg's case he agreed with Mr. Maunder that the union was rather feeble, and it was a question whether amputation would not have proved more satisfactory.

Mr. Mac Cormac did not think it a case of excision of the ankle-joint, and, therefore, it ought not to be classed as such. This operation was not so uncommon as Mr. Maunder appeared to believe; it had been performed at St. Thomas' Hospital several times of late. Prof. Langenbeck's plan of proceeding was a very simple one, and he would advise every Fellow to refer to it before undertaking any operation of the kind.

Mr. Spencer Watson mentioned a case in which the bone protruded through the skin, the result of an injury; in this there was no difficulty in enucleating the astragalus and removing it, also a portion of the os calcis. The incisions indicated in this case by the form of the accident would, he thought, answer equally well in cases of caries.

Mr. Richard Davy also considered the case miscalled. He believed the high boot to be a great mistake. His experience was contrary to that of Dr. Lichtenberg; he had seen the disease recur, which inclined him, therefore, rather to advocate Professor Syme's operation.

Dr. Edmunds, before commencing his paper on

CÆSAREAN SECTION,

brought before the Society the mother and her infant, who were the subjects concerned in this operation.

He also called attention to the instrument invented by Dr. Robert J. Lee, which had been employed for keeping up a carbolised spray while operating. He then read the paper, of which the following is a brief abstract.

It was the second case of Cæsarean section which he had performed; the details were practically identical in each, and in both the mother and child recovered perfectly, and rapidly. Stress was laid on a method of manipulating the uterus before the final closure of the abdomen, with a view to the prevention of subsequent hæmorrhage. Care had been taken to exclude all sources of septic infection, and oleum terebinthinæ as a hæmostatic was spoken highly of.

No sutures had been placed in the uterus, and with regard to their use Dr. Edmunds argued that *à priori* on the physiological properties of uterine muscles the *onus justificandi* was cast upon those who inserted sutures into an irritable mass of muscle such as the uterus. Referring to the past history of Cæsarean section Dr. Edmunds considered that a majority of deaths were to be attributed to causes quite apart from the operation itself; and he described the patients on whom it had been done as many of them moribund from exhaustion, or fatal injury caused by misdirected interference, and argued that others died in consequence of septic poisoning in the course of the operation, or of the influence of opium, of alcohol, or of other drugs, in the course of the after treatment. After urging that the operation was of much more general interest than ovariotomy, and other great operations, for which time, place, and special experience could always be commanded, Dr. Edmunds argued that Cæsarean section, apart from the danger of internal hæmorrhage after closure of the abdomen, need not be more than half as fatal as ovariotomy, insomuch as in the latter operation adhesions had often to be combated, extensive interference with the peritoneum was necessitated, and often the complications of malignant disease were discovered after the operation had been begun.

The discussion of this paper was adjourned until Monday next, the 4th of December.

Monday, December 4th, 1876.

William Adams, F.R.C.S., President, in the Chair.

Dr. Routh opened the discussion on

CÆSAREAN SECTION.

Dr. Routh said, in judging of the causes of success in this case, so well described by Dr. Edmunds, we should remember the patient was placed in a room well purified by antiseptics; all was scrupulously clean, a nice fire, every comfort, not usual when we are called upon to perform Cæsarean section suddenly. 2nd. The position

during the operation was that adopted by Dr. Tyler Smith in ovariotomy. One disadvantage of such was exactly as in ordinary tapping, that unless a bandage was applied to compress the abdomen while the fluid was let out (such could not be done in either ovariotomy, or Cæsarean section), fainting would result. He could conceive that in a case with much liquor amnii a similar result would follow. In this case the membranes had ruptured before operation. 3rd. As to ligatures to the uterus, he thought Dr. Edmunds was right in supposing that they provoked uterine contractions locally, and thus prevented the occurrence of cut edges. In Dr. Meadows' case, and in one of his own, catgut ligatures were used, and had become untied, possibly from the effect of such contraction of the muscular fibres of the uterus, as they did not usually do so elsewhere. 4th. The diagonal incision here made necessary by the position of the uterus; in such, if possible, more need was indicated for uterine sutures than in other instances, yet they were not applied, but Dr. Routh noticed one circumstance—for nearly three quarters of an hour, at least, the lining membrane of the uterus was kept irritated by the fingers and ice, and by a bougie passed through the uterine cavity, and removed per vaginam. This led at last to a firm contraction, which was permanent. The success in this case proved the wisdom of such a course before closing the wound. 5th. The exposure of the gaping parts all this time to the air without result was not followed by any disadvantage, but probably this was due to the spray of carbolic acid, which was made to play upon them all the time through Dr. Lee's beautiful little instrument. 6th. No alcohol was given. This was fortunate; but too much stress should not be laid on this. Formerly, alcohol and opium were thought necessary after every operation; how many cases of operation, and ovariotomy, did not need them at all? Then the patient got turpentine, which is certainly a stimulant. Beside the stimulant effect of turpentine, did it act as a hæmostatic? He had never tried it in menorrhagia, but it certainly was very effective in hæmoptysis, and even sometimes in hæmatemesis. 7th. In this case nothing but Cæsarean section was admissible. Superiorly, at the brim, the diameter was at most only one and a half fingers wide. Any attempt to remove part of the tumour before labour could only have ensured septicæmia.

Dr. Heywood Smith would like to know whether it was a fact that the position in which the patient was placed during the operation

entirely prevented the regurgitation of fluids into the cavity of the pelvis, for it seemed to him that unless the patient had leaned more forward there was still the possibility of fluid running backward into the cavity of the abdomen. He thought there was not sufficient proof that the turpentine administered was the cause of there being so little hæmorrhage, Dr. Edmunds' manipulation of the uterus being sufficient in itself to control it. In a conversation some years since with Dr. Kilian, of Bonn, the latter had strongly recommended in Cæsarean section that the incision should be made diagonally through the uterine wall, instead of in the ordinary direction. He thought that by this means the contractile tissue would be divided through planes, whose fibres varied in direction, instead of through the aponeurosis, as it were, and thus the edges would be less liable to gape; from this he concluded that Dr. Kilian did not employ sutures.

Mr. Spencer Watson was inclined to attach more importance to Dr. Edmunds' precautions with regard to strict cleanliness than to the influence of the so-called antiseptic atmosphere. The recent experiments of Braidwood and Vacher demonstrated conclusively that even tolerably strong aqueous solutions of carbolic acid (part 1 in 20) do not destroy the vitality of vaccine lymph, when the lymph and the carbolic solution are mixed in equal proportions. It is, therefore, difficult to conceive that any solution of carbolic acid in the form of spray can produce a truly antiseptic atmosphere.

Dr. Lawson did not see the rationale of Mr. Spencer Watson's argument. There could be no analogy between the action of the carbolic acid on vaccine lymph and that on the atmosphere of the room, the relative proportions of the disinfectant being totally different.

Dr. Galabin looked with envy on Dr. Edmunds' successes. He had twice lately performed the operation under very disadvantageous circumstances; in each case he had employed sutures. He considered that when the uterus could not be made to contract, or to remain with its cut edges in apposition, the only chance would be with the use of sutures. In his cases ice and perchloride of iron had failed to cause contraction. With regard to the kind of suture, in his last case he had made use of stout fishing gut; the patient died in forty-eight hours, and the autopsy showed that, though the uterus was full of black clots, due to the perchloride of iron, none had escaped through the incision made in the uterine wall, the

sutures having held firmly and not slipped in the least degree. He would prefer this variety of suture to those of silk or silver.

Dr. Rogers had assisted in four cases, in two of which silver sutures had been used, in one catgut. Both the silver, and the gut had cut through the walls, causing the wound to gape. If he were to employ any suture he would prefer silk, but he thought Dr. Edmunds' cases showed the advantage of employing no sutures at all. He considered the wonderful successes that followed the operative procedures at the Samaritan Hospital proved how unnecessary was the carbolised spray.

Dr. Grigg had performed the operation once, and had used, by the advice of Mr. Spencer Wells, the continuous suture. It was seen when the post mortem was made that half of the suture had worked its way out. He had carried his incision beyond the internal os, a course which he knew Dr. Greenhalgh strongly deprecates.

Dr. Fothergill thought that the physique of the patient ought to be taken into consideration while discussing the causes of success, or failure. He believed, from the aspect and history of the patient lately operated upon by Dr. Edmunds, that she would have lived through almost anything, whether suture had, or had not, been used. Too much stress ought not, therefore, to be laid upon this point. The recovery of the patient without the administration of alcohol was in itself a proof of the stamina she possessed.

Mr. Davy thought that we should never put a foreign body into a muscular organ. He understood that Mr. Lister was having manufactured a new catgut which it was believed would not unravel.

Mr. Napier would suggest whether it would not be possible to take the gut fresh from an animal for employment as sutures; in this condition it would be most unlikely to unravel. He had seen Dr. Edmunds' patient on the third day after operation, and could testify to the excessive care bestowed on her.

Monday, December 11th, 1876.

William Adams, F.R.C.S., President, in the Chair.

Mr. Spencer Watson exhibited

A CASE OF CYSTIC POLYPUS OF THE NOSTRIL.

"Miss D—, æt. 15, had for several years past suffered from discharge from the left nostril, for which she had been under treatment in Sydney. Latterly the nostril has become partly obstructed, but no polypus has been detected. Early in the present year she was brought to England, and I first saw her on May 2nd. Her aspect was that of a delicate, clear-complexioned, fair-haired girl, somewhat slight, and small for her age. She had been always delicate, and some members of the family were supposed to be consumptive.

On examining the nostril I found a gelatinous-looking polypus occupying the upper part of the meatus. The passage, however, was not completely obstructed, and the patient suffered most inconvenience from the flow of mucus, and the sense of fulness, and stuffiness. I at once told the parents that a polypus existed, and that an operation would probably be necessary for its removal, but at the same time thought it worth while to use astringent snuffs, and injections, in the hope that the growth might be made to shrivel up. The patient was not very well under her parents' control, and hence I am not quite sure that the astringents were effectually applied, but there was certainly no diminution in the amount of the obstruction. In the beginning of June the nostril had become completely obstructed, and the ala visibly protruded towards the cheek. In the passage a pale grey, semi-translucent polypus was seen to reach almost to the orifice, and the nasal process of the superior maxillary bone of the left side was somewhat expanded by the pressure of the growth.

On June 17th I passed Hilton's snare, and cut through the attached border of the principal bulk of the polypus. There was a gush of mucus and sero-pus, but the polypus remained lodged in the nostril. It was, however, easily lifted away by the canula forceps. During this operation the patient was under the influence of the

mixed vapours of alcohol, chloroform, and ether, as administered by Mr. Eades.

The polypus, when recent, was of the size of a small walnut, oblong-oval in form, smooth, and rounded, and attached by a broad base extending along the whole length of one of its sides. The section of this growth displayed a multilocular cystic formation, the cysts varying in size, some being capable of holding a split pea, but most of them being much smaller, and some being only of microscopic dimensions. They contained tolerably clear mucus, with occasional opaque yellow masses of agglutinated epithelium. The microscopic characters of the cystic contents were those of ordinary mucus, but some loose pieces of columnar epithelium were here and there found floating in this mucus. I could not make out that the cyst-walls were lined with any regular epithelial layer, but it is probable that this must have been so at some period of the growth, as it is difficult to account for the presence of mucus without presupposing a secreting glandular epithelial lining of the cyst containing it. A very few days after this operation it became evident that a considerable mass of the same kind was still left in the nostril, and though the patient was quite relieved, and felt no obstruction, I strongly urged another operation, and on June 30th removed several other large fragments. The remainder was removed on August 2nd.

These growths had exactly the same structure as the portions previously removed, and were probably attached along the free border, and perhaps in the concavity of the second lower turbinated bones. After each operation I touched the points, and surfaces from which they had been removed, with Liq. Ferri Perchl. After the last operation I employed the Arg. Nit. Mitig.

On August 23rd I found that the right nostril was partly occupied by a small tumour high up, and coming probably from one of the upper turbinated bones. The left nostril seemed to be entirely free. I was unable to operate on the right nostril, as the young lady was obliged to accompany her parents on their voyage back to Sydney. It is to be feared, therefore, that there will be a repetition of the proceedings above described when she reaches Australia.

There seems to have been some difficulty of diagnosis in the early stages of this case. Probably the tumour, in the first instance, was high up and small, and hence the inspection of the nostrils did not suffice to give the surgeons in Sydney a clear view of the growth. When the patient came under my care it had increased very much

in size, and was therefore more easily seen. The striking diagnostic feature of these mucous polypi, viz. their translucency, was very well marked in this case. In order to demonstrate it a strong light is necessary, and the light must be concentrated on one point, or side of the tumour, the remainder of its surface being in comparative shade.

This method of inspection, which may be called *transillumination*, is extremely useful in many cases of intra-nasal disease, and in some cases of polypus in which the surface of the tumour is covered with pale pink membrane; the resemblance to the slightly swollen membrane of the turbinated bones is so great that the translucency of the polypus is the only distinctive feature as derived from ocular inspection. The same quality helps to distinguish the fibrous growths, occasionally met with, from the mucous or gelatinous."

Microscopic specimens of this tumour were exhibited.

Mr. Spencer Watson also showed

A PENDULOUS TUMOUR OF THE TONGUE.

"This little tumour, which, when fresh, was about the size of a kidney-bean, was removed from the tip of the tongue of a woman of about thirty-five years of age, at the Great Northern Hospital. It hung by a very narrow pedicle, and had been growing for about a year. It was noticed by the patient, at first, as a raised ulcer or pimple. It was irregularly oval in shape, flattened, of a purplish red colour, with yellowish white edges, and a smooth polished surface. It was troublesome, by getting in the way of the front teeth during mastication, and it also slightly interfered with speech.

I removed it by strangulating the pedicle with a loop of steel wire, cutting off the growth beyond the wire, and leaving the loop to cut its way through, or separate with the slough. The wire separated with a slough of pedicle on the third day, and on the fifth no trace of the growth was visible.

A microscopic section of the growth displayed a structure closely resembling the *gliosarcoma* of Virchow. That is to say, it was made up of round cells, such as those seen in ordinary granulations, embedded in a homogeneous intercellular substance, each cell being separately enveloped by a thin layer of this intercellular matrix. I regard this growth, therefore, as a granular sarcoma. Perhaps, in

its early stages, it may have been what the laity call "proud flesh," but, in its condition at the time of removal, it differed from the flabby œdematous granulations which are generally known by the name of "proud flesh," being much firmer and more solid-looking, and in having no appearance of œdema. I have not been able to find any record of an exactly similar case, but Mr. Francis Mason has recorded a case of two congenital pedunculated fibro-cellular tumours of the tongue (in 'Pathological Transactions,' vols. xv and xviii) in a woman æt. 27. These resembled gelatinous polypi in form and structure. There is also a case of polypus of the tongue recorded in 'Edin. Med.-Chir. Trans.,' vol. iii. The reporter of this case, Dr. Richard Hine, describes this as "a polypus of great size removed from the root of the tongue by ligature." This polypus, after removal, weighed about an ounce, and was 4 in. × 5 in. It had a cartilaginous nucleus, surrounded by a fibro-cartilaginous structure. It was supposed to have begun to grow after a severe catarrh twelve months before. This patient was also a woman, and between forty and fifty years of age.

Mr. Lennox Browne considered the suggestion of one blade in each nostril a decidedly good one. When both were placed in a single nostril a great deal of pain was complained of from pressure on the septum. The instrument for reflection was most ingenious, but he doubted its efficacy in practice.

Mr. Mason inquired whether the tumour extended into the pharynx, and whether Mr. Watson had used the light to get the snare round it.

Dr. Lawson considered the term speculum misapplied; the instrument was merely a dilator.

Mr. Maunder asked whether the finger would not, as a rule, be preferable to the dilator.

Mr. Mason said that he had had under his care at St. Thomas's Hospital, during the last four or five years, two or three cases resembling somewhat in their nature the pendulous tumour of the tongue described by Mr. Watson; they had not, however, the narrow pedicle, nor were they removed. He would ask whether there was any history of syphilis in Mr. Watson's case.

Mr. Bloxam made some remarks in disparagement of the form of anæsthetic employed, namely, a mixture of ether, alcohol, and chloroform.

Mr. Lennox Browne showed three specimens—1. A pedunculated warty growth from the uvula causing persistent laryngeal spasm for forty-eight hours, the attack arising as the result of catarrh. On examination the uvula only appeared very elongated, and the end could not be seen, but on attempting to examine the larynx, the growth was seen attached by a long pedicle. It was immediately removed, and with it all the disagreeable symptoms. The patient had had syphilis five years previously, and Mr. Browne stated that in his experience these growths were always of specific character.

2. A fibro-cellular polypus removed entire by means of Purves's hook-knife. The polypus took the exact shape and curves of the auditory canal in which it lay. Mr. Browne mentioned that the best application to prevent recurrence was tannin powder, or subchloride of mercury, blown in after all hæmorrhage had ceased. He had learned the latter treatment from Dr. Andrew, of Shrewsbury, and had found it much more successful than escharotics.

3. A laryngeal polypus removed from beneath the left vocal cord, at its anterior insertion, by means of Gibb's original wire écraseur. Mr. Browne had always held that wire-loops and écraseurs were safer than unguarded forceps, as less likely to injure the healthy portions of the larynx. On this occasion he had used external pressure over the thyroid cartilage during the time of withdrawing the loop, with the result of causing removal from this—the most difficult situation for operation—much more easily than is usually the case.

Mr. Dalby said there were three points of interest in connection with aural polypi:—(1.) The part from which the polypus originates. (2.) The character of the growth. (3.) The complete eradication of the same. Nearly all those which he had removed—in fact, all but one—were fibro-cellular in their structure, and he had found that the length of time occupied in the growth influenced the relative proportion borne by the fibrous or cellular elements; the one exception to these was a round-celled sarcoma. With regard to their seat, the lining membrane of the cavity of the tympanum was the most frequent; next, the tympanic membrane itself; thirdly, the external meatus, and these are very simple, and very easily eradicated. The difficulty in the treatment of those occupying the first two named situations consists in their complete removal; the whole surface must be most carefully dried, and not only must the

growth be removed, but the mucous membrane from which it arises. Unless great attention be paid to this, so persistent are these growths that they have been known to recur as many as thirteen times. Tannic acid is insufficient as an application to the seat of removal; a powerful caustic must be applied.

Mr. Spencer Watson had seen Mr. Bowman employ a very simple method, a harelip pin. He had since used it himself, and found it very efficacious.

Mr. Mason asked if the patient with the growth from the uvula experienced any difficulty while eating, as this had been a prominent symptom in a case of the kind which he had met.

Mr. Royes Bell inquired if vomiting had been caused by this growth, as he had noticed it in connection with elongated uvula.

Mr. Llewellyn Thomas thought that in elderly people the uvula got sucked into the larynx, and gave rise to symptoms which were attributed to asthma and phthisis. He considered removal of the uvula in well-selected cases a most successful operation. He had frequently performed it for professional singers, who could subsequently command two notes higher.

Dr. de H. Hall could bear testimony to the difficulty of snaring these polypi. He had seen one of the aretenoid cartilages grasped in mistake for a polypus attached to the vocal cords. The sensation conveyed was that of a firm body instead of a soft one, and thus the error was detected.

Dr. Dowse showed a specimen of

ANEURISM OF THE CŒLIAC AXIS OF THE ABDOMINAL AORTA.

It was removed from a man 40 years of age, who was a baker by trade. The clinical features were as follows, viz.—That in the month of May, 1875, he first felt pain at the lower part of the chest, which was worse after exertion. In the following August the pain extended higher up the chest, and the only inconvenience which it gave him was difficulty in swallowing. There was no hæmorrhage, vomiting, dyspnœa, vertigo, or palpitation, but there was an aortic diastolic grind from incompetency of the valves. Immediately below and a little to the left of the xiphoid cartilage was a pulsating tumour, which was influenced in position by the movements of the diaphragm; its impulse was not immediately synchro-

nous with the heart's systole, but in rapid succession, and terminating with the ventricular diastole. Auscultation gave a marked grind at the time the column of blood was passing, which was heard over the iliac and femoral vessels, and although there was great tenderness over the tenth and adjoining dorsal spines, yet no bruit was heard in this position. The patient died suddenly from rupture, and hæmorrhage into the peritoneal cavity. At the post-mortem examination the left side of the heart was found much dilated, and the thoracic aorta atheromatous to the aneurism, but below the aneurism the abdominal aorta was healthy; the aneurism itself was about the size of a cricket-ball, and involved the three branches of the cœliac axis, but more particularly the gastric. The seat of rupture was at the back of the sac; the bodies of the vertebræ were considerably eaten away (ulcerative absorption), but the cartilages were left entire. Dr. Dowse remarked that had not the man died so suddenly he intended to have tried the effect of distal pressure.

Mr. Maunder said that these cases were not very uncommon; he might have shown one a little time ago. He mentioned it in his Lettsomian Lectures. The man died when under treatment by digital pressure.

The President asked if Dr. Tuffnell's plan with regard to dietary had been adopted by Dr. Dowse.

Monday, December 18th, 1876.

William Adams, F.R.C.S., President, in the Chair.

TALIACOATIAN OPERATION.

Mr. Bloxam exhibited a man upon whom he had performed the Indian operation for restoring a nose, at Charing Cross Hospital. The individual had been for years the subject of lupoid ulceration. This had affected various portions of the body, had attacked the ears, and totally destroyed the cartilages of the nose with the septum; it had also involved the nasal and turbinated bones. A question was raised whether the disease was not of syphilitic origin, but the author of the paper considered it to be "lupus." In the first

operation, performed on October 14th, the flap was dissected from the forehead, and turned down, Mr. Bloxam having previously made a cast of a nose in gutta percha, which was subsequently flattened out, and then the flap from the forehead was cut about one third of an inch larger. Sensation returned in the flap on the third day, and was at first referred to the forehead, but after the sixth was always referred to the new position of the skin, the edges of the wound having completely united. At the end of three weeks the edges of the twisted pedicle had also united, and lay like a cord between the eyebrows. Mr. Bloxam then proceeded to form the septum from the upper lip. The peculiarity of this operation consisted in taking a large flap of the mucous membrane laterally, and then uniting it to the central portion of skin, and finally uniting it to the body of the nose with a harelip pin, and so forming a septum.

On December 9th the pedicle was divided, and smoothed out at the root of the nose.

The wound of the forehead was simply dusted with the oxide of zinc powder, and allowed to heal by the scabbing process, as Mr. Bloxam considered this the best method to avoid a large scar.

Dr. Routh had seen several of these operations performed by the late Mr. Liston. He wondered why it should be called the Indian operation. Mr. Liston was in the habit of taking a little finger of skin at the summit of that intended to form the alæ, which he might turn down so as to constitute a frænum. He used to ask the patient the style of nose he would prefer, and then, after cutting the form out of a piece of paper, would place this on the forehead and mark it round as a guide for the incision.

Dr. Lichtenberg congratulated Mr. Bloxam on his success. He hoped the operation would be more frequently performed in this country. It was not popular, probably because English surgeons described it in their text-books as unsatisfactory and dangerous, and advocated instead the employment of an artificial nose. It would be found that patients, however, who wear these look upon them as most disgusting, and Dr. Lichtenberg quoted an instance where a man who wore the most artistic false one he had ever seen begged him, nevertheless, to perform the operation to relieve him of this disgust. He did not consider the operation in the slightest degree dangerous. He usually took the flap one third larger than he wished the nose to be.

Mr. Davy, being associated with a mechanical aid society which

supplies a large number of artificial noses, could state that the objection to these was not so great as had been implied. He had known them worn for seven years. The spectacles were disliked, but they were quite unnecessary. He was glad to find that Mr. Bloxam preferred healing by scab to water dressing.

Dr. Broadbent then read a paper on

WARBURG'S TINCTURE, WITH THERAPEUTICAL COMMENTS THEREON.

The author's attention had been called to Warburg's tincture by public statements, and reliable private testimony as to its remarkable effects in malignant remittent fevers; but, its composition being secret, he had never been able to try it. When, however, Prof. Maclean made known its mode of preparation in the 'Med. Times' in 1875, giving the support of his high authority to what had been said in its favour, he carefully examined it with a view to ascertain the principles upon which its action was based. It contains quinine with a great variety of aromatic stimulants, and the combination evidently *does* what quinine alone will *not* do.

Dr. Broadbent, having resolved to test the tincture, did so in two cases, which he related.

The first was that of a gentleman, under the joint care of Dr. T. Kilner Clarke, of Huddersfield, and himself. The father of the patient had been gouty, and he had himself at the age of forty or thereabout suffered from severe vertigo, which was considered to be gouty. He was put upon a most restricted diet, from which alcohol in all forms was excluded, and reached the age of seventy-nine, sound and hale in body and mind. Early in 1876 he took cold, and with bronchial catarrh, was feverish, and suffered from severe rheumatoid pains, chiefly in the shoulder, which interfered with sleep. This condition lasted many weeks, and his strength was greatly reduced, so that when convalescing he had a heavy fall, which was nearly fatal at the moment from shock. There was an entire suspension of the secretion of urine for twenty-four hours, but, when it returned it was at first ammoniacal, and escaped involuntarily. Having rallied from this shock it was hoped that there would be a gradual return of strength, but the pains and sleeplessness returned, the appetite failed, and eventually there was delirium, jactitation, a dry tongue, and all the indications of impending death.

At this crisis, everything else having failed, Warburg's tincture was given; the immediate effect was a sleep of twenty-four hours, with copious warm perspiration, and the ultimate result recovery. This gentleman has taken Warburg's tincture ever since, more particularly on account of its action on the bowels.

Another case related was that of a boy suffering from scarlet fever, attended with extremely rapid pulse and respiration, in which, in the opinion of all who saw the case, life was saved.

Dr. Broadbent finds the good effects of the tincture to be due to two principles:—One is the combination of quinine with aromatic stimulants, the advantage of which is recognised in ordinary doses, as is shown by the compound tincture of bark, but less appreciated when quinine is employed in large doses. He has found subsequently to his study of Warburg that large doses of ext. cinchonæ, and large doses of ether, were successful in cases of extreme prostration after enteric fever, when, in his judgment either, singly, would have failed. In combination he has long employed a dose of quinine, with strong black coffee, and brandy. The second therapeutical principle, of which advantage is taken in the use of Warburg's tincture, is concentration, and this Dr. Broadbent considered an illustration of the therapeutical administration of remedies as compared with the so-called physiological administration, guided by the physiological effects and rate of elimination of the drug. The patient as well as the remedy must be considered. Other illustrations named were opium in post-partum hæmorrhage, undiluted brandy in syncope, quinine in large doses in ague or neuralgia. The mode of action in many of these cases is by a powerful effect on the nervous system, and it is in this way that camphor, cajuput oil, and strong stimulants, such as ether, with lavender, capsicum, &c., will often arrest diarrhœa, which astringents and opiates had not checked.

Further illustrations of the therapeutical employment of remedies, *i. e.* not only the selection of the remedy, but its dose. Quinine in pyrexia, salicylic acid in acute rheumatism, salts of ammonia, with opiates, &c., in catarrh, large doses of laudanum in tympanitis occurring during fever.

Finally, attention was drawn to the various ways in which it may be seen that the nervous system succumbs to some morbific influence. One of these is hyperpyrexia, in which the nervous system abdicates its control over the temperature, as seen in acute rheumatism, from injuries to the head, &c.; for this the cold bath is the remedy,

and to Dr. Wilson Fox belongs the honour of first bringing back to life a patient whose temperature reached 110° F.

Another of these signs is extreme frequency of pulse; another, again, extreme frequency of respiration, which is much more rare, for which reason an illustration was given. A gentleman of magnificent physical conformation had given himself up to all forms of excess. For many years he drank six bottles of wine per day. When first seen by Dr. Broadbent he was suffering from ascites and congestion of the liver, to which was added, within twenty-four hours, delirium tremens, and within another twenty-four hours fracture of the forearm. He recovered, and was for a time more moderate, but renewed excesses brought on epileptic mania of extreme violence on two occasions. Finally, he took cold from prolonged coaching expeditions. The symptoms were at first simply those of catarrh, but gradually the breathing became extremely rapid, without physical signs of lung or heart affection, or elevation of temperature, and ultimately delirium. Convulsions and coma came on and ended in death. Venesection, rejected by friends until the last moment, was in this case apparently of great use, but too late.

A final illustration was tympanitis, already spoken of in the paper.

Monday, January 8th, 1877.

William Adams, F.R.C.S., President, in the Chair.

Dr. Wiltshire delivered the first Lettsomian lecture, subject—

VASCULAR RHYTHM AS EXEMPLIFIED IN PERIODICAL HÆMORRHAGES, ETC.

Monday, January 15th, 1877.

WILLIAM ADAMS, F.R.C.S., President, in the Chair.

DR. SANSOM read

CASES ILLUSTRATING ABNORMAL CONDUCTION OF MITRAL MURMURS.

CASE 1.—*Systolic murmur and thrill, maximum in tricuspid area; mitral obstruction and incompetency; orifice surrounded by calcareous ring.*—C. D—, æt. 24, admitted into London Hospital on August 14th, 1876, under Dr. Sansom.

History.—Three attacks of acute rheumatism; once in hospital with endocarditis; presystolic murmur then observed. Since last attack much palpitation, causing loss of sleep.

Physical signs.—Visible pulsation over wide area; apex beat, half an inch below and left of normal impulse, heaving; strong thrill, maximum a little left of base of ensiform cartilage, and extending about an inch towards apex. Loud musical first-sound murmur, maximum at base of ensiform cartilage. Right-side dulness extended one inch to right of right border of sternum. Subsequently aortic second sound became enfeebled, whilst pulmonary second sound became exalted. Right-side dilatation increased, and then pulsation in jugular veins. Dyspnœa progressively increased. Patient died suddenly on October 16th.

Diagnosis.—From the position of the maximum intensity of the murmur one was inclined to the diagnosis of tricuspid regurgitation. I had never heard a tricuspid murmur having the pronounced musical, and vibratory character, of this one. A valued colleague, however, had had such experience, and inclined to this view. My conclusion was that the phenomena were all due to disease of mitral orifice, the sounds produced being abnormally conducted.

Post-mortem examination showed a heart hypertrophied and

dilated. Mitral orifice admitted only one finger, and was surrounded by a dense calcareous ring. The calcareous material was attached in largest mass to the inter-ventricular septum; it would thus very probably act as a conductor of sound directly to the right apex. Left auricle much dilated; all centres filled with blood. Old pleurisy-pneumonic consolidation of right base.

Case 2.—*Musical presystolic murmur, maximum intricuspid area with systolic mitral; ascites; albuminuria; glycosuria; mitral obstruction, and insufficiency; calcareous mass attached to interventricular septum.*—T. T—, Esq., æt. 50, consulted on July 17th, 1874.

History.—Had chorea at 8 years of age, and scarlatina at 14. Never had rheumatic fever, but rheumatoid pains, especially lumbar, Lately much dyspnœa on exertion, and orthopnœa at night; occasionally paroxysmal dyspnœa. Cough; morning sputa.

Physical signs.—No signs of altered position. Just left of base of ensiform cartilage, short, whistling, musical presystolic murmur; on approaching apex this is found to be immediately followed by a loud, rushing systolic murmur. No thrill.

August 2nd, 1875.—Presystolic murmur had ceased to be audible; there was no musical sound; loud first-sound murmur. Signs of hypertrophy, and dilatation.

October 15th.—Œdema, ascites, albuminuria. Under treatment (digitalis), symptoms greatly amended, and patient was able to do his ordinary work as solicitor.

July 16th, 1876.—Ascites again manifest; great dyspnœa, and urgent distress. Paracentesis abdominis was twice performed with relief. Urine had been loaded with albumen, and previously to the last paracentesis had been very scanty. Immediately after the last tapping, however, urine was greatly increased in quantity; there was much thirst, and urine was *loaded with sugar*. There was marked pulsation of the liver, and the jugular veins showed a decided pulse. Patient died November 1st, 1876.

Diagnosis.—In this case, fortified by experience, I was able to arrive at a correct diagnosis, which was to the effect—that there was mitral constriction, the characteristic presystolic murmur of which had been conducted by dense material to the interventricular septum, and then towards the right apex—that, considering the musical character of this murmur, the valve aperture was probably

a calcareous ring—that this murmur had ceased to the ear because the left auricle had become dilated, and its muscles enfeebled—that there was in addition incompetency both of mitral and tricuspid valves.

Post-mortem examination exactly confirmed this opinion. There was a "button-hole" mitral orifice, roughened on its right side by calcareous matter, which constituted a plate of almost stony hardness.

Dr. Fothergill said that he was pleased to hear that the post mortem in one case enabled Dr. Sansom to make the diagnosis correctly in a second.

Dr. de Havilland Hall asked over what area the presystolic murmur was heard. Was it heard behind?

Dr. Dowse inquired if the cardiograph had been used. Dr. Galabin had used this instrument with advantage. Mitral murmurs were more difficult to diagnose than aortic.

Dr. Thorowgood had been enabled to diagnose calcification of the mitral valve, but Dr. Sansom's case afforded confirmatory evidence of its correctness.

Dr. Routh stated that musical sounds were produced by rapidity of vibration. He narrated a case of enlargement of the heart where extravasation of blood had occurred into its walls. He inquired the state of the pulse, for musical sounds were intensified by a quickened pulse.

Dr. Edmunds stated that a small mitral aperture would yield a higher pitched note than a larger one. He thought that the exaggerated sound might be accounted for on ordinary physical laws.

Dr. Sansom, in reply, said that the area of localisation of musical note was limited. The sounds were not heard at the back; the cardiograph had not been used.

TAPEWORM, WHICH RESISTED OTHER REMEDIES, CURED BY TURPENTINE.

Dr. Leared related the case of a gentleman under his care who took large doses of kamala, followed by the expulsion of a large mass of tapeworm, but after some weeks the worm again made its appearance. Liquid extract of male fern was then administered in large doses, with the same results.

A combination of kamala, male fern, and kousso, was next employed, each in full doses. Nevertheless, the whole worm was not destroyed, as proved by the reappearance of proglottides in the fæces after some time.

Spirits of turpentine was next given, the same precautions as to fasting having been observed as when the other drugs were exhibited. This was followed by the expulsion of the entire worm. Examination of the head proved it to be that of *Tænia mediocanellata*. This worm, Dr. Leared observed, is far more difficult to expel than *Tænia solium*. He also stated his conviction that turpentine is the most powerful of all tæniacides, but that its administration is not free from risk, and that he knew of death resulting in a case in which turpentine was taken for tapeworm. The risk, he said, was much diminished by keeping the bowels open.

Dr. Brunton stated that the remedy for tapeworm that will answer in seven cases will fail in the eighth; possibly the drugs were at fault.

Dr. Hall narrated a case of tapeworm where turpentine was given after male fern had failed. Strangury and hæmaturia succeeded. These symptoms were relieved by hyoscyamus.

Dr. Routh advocated complete fasting for two days prior to the use of the oil of male fern.

Monday, January 22nd, 1877.

William Adams, F.R.C.S., President, in the Chair.

Dr. Wiltshire delivered his second Lettsomian lecture.

Monday, January 29th, 1877.

WILLIAM ADAMS, F.R.C.S., President, in the Chair.

DR. DOWSE read a paper on

DIPHTHERITIC PARALYSIS,

of which the following is an abstract:

"It is well known that this especial form of paralysis has been seen to succeed an attack of diphtheria, or an inflammation of the throat, from the time of Hippocrates. So that in the fact of the existence of this especial paralytic affection we have nothing new, yet in its peculiar clinical and characteristic features we find a disease of most absorbing interest, both in regard to its etiology and pathology. Its diagnosis is easy, and its prognosis favorable.

In my own experience, and I believe it is considered to be the rule, it has been impossible to state with any degree of certainty in what patients an attack of paralysis is likely to supervene that of diphtheria, although Dr. Balthazar Foster states that he has never known paralysis to follow the non-febrile form of diphtheria. For we often find a very severe attack of paralysis to follow a slight or most modified attack of diphtheria, whilst, on the other hand, a very severe attack of diphtheria will be unaccompanied with paralysis. Neither have I been able to trace in the constitution of the patients any especial nervous idiosyncrasy to render them more prone to paretic influence, but my knowledge of this disease is not so extensive as to permit me to speak with certainty upon this point.

But, judging from other nervous diseases, such as chorea, hysteria, tetany, and so on, I think we should find, if the matter were more closely investigated, that in those persons suffering from paralysis after the devitalizing agency of some septic or morbid influence, that there was, either by hereditary or some constitutional predisposing cause, a want of inherent tonicity throughout the nervous system and nervous centres, which renders them more easily excited, or acted upon by external agency. This is conspicuously demonstrated in the poisoning by lead. Some men will go all their lives, and get

their systems saturated with lead, without any form of paralysis resulting, whilst others, even from the application of lead plaster or ointment to the skin, will suffer from palsy of the extensors, or abdominal muscles.

M. Sanné states that the red blood globules are altered in various ways, notably when the blood takes abnormal colourings. The abnormal increase of the débris of the red corpuscles, which is rare in the normal state, is considerably increased through the agency of the diphtheritic poison which produces their rapid destruction.

Consequent upon this alteration in the normal constitution of the elements of the blood, we find the urine to be loaded with albumen, which, as stated by Dr. Sanderson, is not associated with a lessened excretion of urea, but rather, as in other pyrexia, by its abnormal increase, therefore, we are not likely to get any form of convulsions, or paralysis, of toxic or uræmic origin. I make note of this especially for the reason that the stage at which diphtheritic paralysis makes its appearance, is usually subsequent to what may be called the albuminuric period. Frequently not a trace of albumen can at the time be detected in the urine, although a copious production previously existed, yet it is by no means rare for the albumen to reappear with the paralysis.

The coexistence of albumen in the urine in various forms of paralysis, (not diphtheritic), has upon many occasions led me to give a hopeful prognosis, and as the albumen passed off, so the paretic troubles have gradually declined, showing that the nerve lesion was merely functional, and due to some blood change inducing a vasomotor paresis, leading to passive exudation of primordial plasmic matter, not only from the blood-cells themselves, but also from the vessels, thereby exercising pressure upon the nervous centres.

We have now first to consider the period when this paralysis first makes its appearance, and then proceed to describe its clinical characteristics, treatment, and pathology.

On the authority of M. Sanné, if during convalescence from diphtheria the temperature suddenly rises, paralysis must be anticipated. There can be no doubt that it is capricious alike in its origin, seat, and departure; sometimes it is fixed to one organ, at others attached to many, or it may involve the whole body. It is sometimes limited to the throat alone, and to those muscles supplied by nerves taking their origin in the bulb of the medulla, and so far it represents in a very striking manner what is termed labio-glosso,

pharyngeal, or bulbar paralysis, but there are marks of distinction which I will endeavour to draw as I proceed.

Paralysis may occur in a few days after the cure of diphtheria, or it may not make its appearance for a month, six weeks, or even two months. It is usually symmetrical when it comes on; later it is frequently found to be more persistent than when it occurs earlier after the presumed cure of the disease, although in the latter case it is liable to recur in some different form.

The duration of the paralysis cannot be well defined. When it is limited to the throat, or larynx, it does not usually exceed eight or ten days, but even here it may last longer, and end in fourteen, or twenty days.

The mind and intellect are rarely, if ever, brought under its influence.

According to Brenner, the troubles of motility are of three kinds:

1st. The true ataxic, caused in all probability by lesion of a centre for the co-ordination of movements.

2nd. An ataxic paralysis, characterised by a paresis of certain groups of muscles of the extremities over those of other groups.

3rd. A true paralysis, which attacks alike all the muscles of the limbs, and which can be complete, or incomplete.

The irregularity of the paralysis in muscular groups can, indeed, give rise to movements resembling those of chorea.

We will now take the paralysis of the cranio-spinal nerves in anatomical sequence:

1st. Some authors assert that the sense of smell is rarely interfered with, but in all my own cases it has been almost obliterated.

2nd. The defect of sight, according to Von Graefe, is due to paralysis of the muscles of accommodation, rather than to any retinal change. M. Parchant states that in cases of amblyopia associated with paralysis there has been found by the ophthalmoscope a neuro-retinitis similar to that produced by alcohol and tobacco. There are three interesting cases of this condition published by Mr. Hutchinson in the 'Lancet' for January 7th, 1871. It is observed that the patient is generally a child, that the defect of sight has come on suddenly, and consists usually of inability to read. The ability to see well at a distance, and to read with the assistance of a strong glass, at once establishes the fact that the only disease is a paralysis of the muscles of accommodation.

3rd, 4th, 6th. Of the ocular muscles I have usually found the sixth to be more involved than the others, and the patients to have an internal squint. Ptosis is by no means common, yet there is a heaviness of the eyelids, showing that the third nerve is not quite free.

5th. This nerve is usually involved, both in reference to its motor, and sensory supply. The jaw in some cases is depressed with the greatest difficulty, and there is almost complete absence of sensation of the face.

7th. Both the portio dura, and mollis, are in like manner affected, owing to the paralysis of the facial muscles, conjoined with those of the neck; the chin falling forward upon the chest, the patient presents a very remarkable appearance. The paralysis of the muscles of the neck is sometimes so great that the head can be impelled from one side to the other in the most ludicrous manner. There is want of voluntary power to blow, whistle, or eject saliva.

8th. The greatest point of interest and importance is attached to the glosso-pharyngeal, pneumogastric, and spinal accessory nerves. First, with regard to the glosso-pharyngeal. We not unfrequently find both dysphagia, and dysphonia, as well as complete loss of sensation of the velum, pillars of the fauces, and the pharynx, and although the patient cannot often speak above a whisper, I have never found the vocal cords to be paralysed. It is often almost impossible for the patients to swallow fluids, as they return through the nose, and on account of the immobility of the tongue, and facial muscles, the food has to be pushed from between the teeth down the throat over the epiglottis, before it can be grasped by the œsophagus. The patient has a horror of, and dreads to take food, whereas in bulbar paralysis there is a voraciousness amounting almost to a monomania, and persons will feed themselves even at the risk of being choked. It is remarkable sometimes to observe how the paralysis may spread from one side of the throat to the other. Paralysis of motion will sometimes pass away, leaving paralysis of sensation, and *vice versâ*. When the pneumogastric nerve is involved we have a series of troubles, referable to the circulation and respiration.

9th. The movements of the tongue are not performed co-ordinately, so that articulation is not complete, and the letter R is the most difficult to pronounce. The very diagnostic nasal twang during the process of articulation must not be forgotten.

Thus, we gather that from the blood changes consequent upon

the devitalising agency of diphtheritic poison a paralysis can, and does often, follow upon the cure of the local malady. That we have no precise data to go upon, from our insufficient knowledge of the subject, to be able to state when paralysis will follow any of the varieties of the diphtheritic manifestations, neither can we state in what especial habit of body it is the more prone to be engendered. That this form of paralysis is peculiar to any other kind with which we have to deal. That in many respects it resembles an hysterical, or reflex paresis. That it may be confined to the nerves of the medulla, or to one single nerve, as the glosso-pharyngeal. That it is usually symmetrical, although often migratory, and not infrequently relapses. That defects of motility, and sensation, usually march hand in hand. But that, whatever especial objective feature of paralysis is represented, we can, if we go carefully into the case, discover a general want of tonicity throughout the whole of the nervous centres. That paralysis of the heart is a most common sequence, and that a recurrence of the throat symptoms may sometimes precede improvement of the paralysis. That it comes itself, or, rather, that its cure can be, and is, frequently accomplished spontaneously without the help of any especial drug. That the trophic nerves are rarely brought under the influence of the diphtheritic agency, as in many other forms of toxic paresis, (in cerebro-spinal meningitis for instance).

We rarely find gangrene, or bedsores resulting, I mean rapidly and extensively, in the course of twenty-four hours or less. There are some cases reported of gangrene of the lower limbs, but these were associated with plugging of the arterial trunks from emboli. There is not, as a rule, muscular wasting; muscular electro-irritability is often impaired, but this is variable.

I will now draw attention to the treatment of this paralysis. As just stated it will run its course, and disappear almost suddenly, but there can be little doubt of this, that its duration can be cut short by remedial agents, of which we have four that are special:

1st. Nutrition.

2nd. Rest.

3rd. Hypodermic injections of strychnine.

4th. The continuous galvanic current.

With regard to the administration of nourishment I adopt the same course that I do in the true form of bulbar paralysis, and that is, to feed the patients at regular intervals by means of india-rubber

tubing passed through the nostrils into the œsophagus. This procedure is of the greatest importance, for the reason that the constitutional disturbance produced by the difficulty in endeavouring to swallow, the sense of choking, and the feeling of almost impending dissolution, is thereby obviated, not forgetting the fact also that we are keeping the paralysed parts from any unnecessary fatigue.

I need scarcely say how much nourishment is needed in these cases, and it is astonishing to see how readily nature will appropriate to herself this material for rebuilding her shattered structure. I usually pour into the stomach a pint of fluid at one time, about every three hours, consisting of milk, beef tea, eggs, and 1 oz. of brandy. The use of the latter under these circumstances is absolutely necessary, not that I believe that of itself it acts as a food, but that it stimulates the vaso-motor nerves of the peptic glands, and increases the flow of gastric fluid, as well as stimulates the veins to absorption. It is a fact that we have a paresis of the coats of the stomach in these paralyses, as well as of the bowels, which cannot be better evidenced than by the subjective phenomena of cramps and strange feelings, as well as by the objective sign of habitual constipation. Strychnine certainly seems to have some specific action in restoring nerve power to the paralysed muscles, and its internal administration is valueless compared to the effect which is produced by hypodermic injection. I usually begin with $\frac{1}{24}$th of a grain, and gradually increase it up to $\frac{1}{6}$th of a grain.

In reference to the use of galvanism I find the continuous, and induced currents, of about equal value. It is of far greater use, I think, when applied to the spine, and the periphery, at the same time. My mode of procedure is to place the feet of my patient in a galvanised zinc bath, partly filled with warm (salt) water, then to carry the sponge reophore from the positive pole of the battery to the spine, and that from the negative pole to the water.

I use Stohrer's 40-celled continuous battery. Lastly, we have to consider the pathology of this disease, which even at the present time might be looked upon as a vexed question, and there are necessarily many theories concerning it.

Pathology.—We find little in the home literature of this country concerning the pathology, and the anatomico-histological changes, found after death from diphtheritic paralysis,

No pathologists of the past few years have given greater attention to the morbid changes of the spinal cord than M. Charcot and M. Vulpian, and their opinion seems to be that the paralysis of diphtheria is due to peripheric rather than to central change in the nervous centres. That it is in fact an extending neuritis or inflammatory process, propagated from the muscular surfaces and nerve extremities, which produce abolition of their functions. They have shown that the normal condition of the palatine nerves is altered. The nerve tubules are devoid of myeline, and granulations are seen to exist in the neurilemma.

These observers have not found any change in the normal structure of the medulla.

We find paralysis not infrequently to result from other exhaustive forms of blood disease, which are described by M. Gubler as asthenic paralysis, and made evident during convalescence.

Dr. Semple stated that Bretonneau had omitted to mention paralysis, which occurred in only one out of eleven cases. The pathology of diphtheria consisted in a molecular derangement of nervous centres not appreciable by the scalpel. It is also peripheral. First noticed in muscles of soft palate; loss of taste, and even general paralysis might follow. He had not seen a fatal case.

Dr. Gibbon thought nourishment and rest were incompatible with galvanism and strychnine. He could not understand Dr. Semple's pathology of diphtheria.

Mr. Spencer Watson believed that visionary defects were due to fault in the muscles of accommodation. Hypermetropia had been noticed as a sequel of diphtheria.

Mr. Brudenell Carter thought the nerve, and not the muscle, was at fault. The muscle might become atrophied by want of use, as in paralysis. The electric current, as also the alkaloid, eseria, of the Calabar bean, did good; practically the muscle responds to this alkaloid.

Dr. Wynn Williams considered that a local poison acting on local nerves represented this disease; a spirituous solution of tannic acid caused this membrane to peel off.

Monday, February 5th, 1877.

William Adams, F.R.C.S., President, in the Chair.

Dr. Wiltshire delivered his third and last Lettsomian lecture, at the conclusion of which the President, in a few complimentary words, proposed, "That the thanks of the Society are hereby given to Dr. Wiltshire for his excellent course of lectures." This was carried by acclamation.

Monday, February 12th, 1877.

William Adams, F.R.C.S., President, in the Chair.

Mr. J. Astley Bloxam, by the permission of Mr. Barwell, exhibited a

SPECIMEN OF FRACTURE OF THE ANTERIOR FOSSA OF THE SKULL.

It was that of the lad who was injured by Major Buckle, of the Royal Artillery, and the case was, no doubt, fresh in the memory of the Fellows. The wound was inflicted with an umbrella, and over the inner side of the left upper eyelid there was an external abrasion, and a fracture passed through the orbital plate of the frontal bone, then directed upwards through ethmoid. A large ragged opening existed just below the bulb of the left olfactory nerve. As the specimen was rare Mr. Bloxam wished to bring it forward, but the case would be more fully published by Mr. Barwell.

Mr. Richard Davy thought the specimen exceedingly interesting as demonstrating a grand pathological fact — how dangerous,

apparently simple wounds are, when received in such a thin portion of the skull as the anterior fossa.

Dr. Woakes read a paper on

SOME SYMPATHETIC EAR SYMPTOMS.

The conditions discussed were based on the frequently observed occurrence of inflammation of the ear, and otalgia, caused by the presence of a decayed tooth, or a sore on the tongue, and the equally common event of spasmodic cough induced by the presence of a foreign body in the meatus. The continuity of sensitive nerve-fibres being deemed insufficient explanation of these symptoms, the object of the paper was to supply the true method whereby through nerve influence a genuine inflammatory action is set up in the ear, the original seat of irritation being widely separated from it. Great stress was laid on the importance of the fact that fibrillæ belonging to the vaso-motor system of the nerves are mingled in the same fasciculus with those of the cerebro-spinal system, the former set of fibrillæ being brought into reflex relationship with the nervi vasorum distributed on the arteries of the part reflexly affected by means of the sympathetic ganglia, in which the two sets of fibres communicate. In this way it was shown that distinct channels of communication exist between the vessel-nerves which regulate the supply of blood to the ear and the otic ganglion, while branches of the fifth nerve connected with the carious tooth, and the ulcers of the tongue, also communicate with this ganglion. It was then indicated how morbid impressions affecting the latter would influence the former, and thereby produce vascular distension of the drum-head and contiguous regions, producing a veritable hyperæmia of these parts, to the consequences of which the pain and inflammation was referred. A similar communication was also traced between the nervi vasorum of the vessels of the larynx, and the auriculo-pneumogastric nerve supplying the meatus, through the medium of which connection a case of laryngitis from the presence of a bean in the external canal was traced. The author concluded his paper with the suggestion that, owing to the sympathy thus established, it was possible for spasmodic cough in children to be due to draughts of cold air falling upon the ear, and advantage was taken of this sympathetic association to suggest a simple method of treatment to be followed in such cases.

Mr. Lennox Browne was of opinion that laryngismus stridulus much more often arose from irritation of the pneumogastric nerve than from anything connected with the ear. He failed to see the practical bearing of Dr. Woakes' paper.

Mr. Pennefather thought sympathetic irritation very common. He knew a case where a watery otorrhœa was produced in a young lady whenever she was disturbed in her mind. He believed that in the majority of cases of ear affection the commencement arose in the throat or nostrils, and not in the ear itself.

Mr. Allingham suggested that the peculiar cough of laryngismus stridulus occurring in the night might be excited by the cold air of the room striking the exposed ear of a child in bed.

Mr. Pugin Thornton referred to the fact of an ulcer being produced in the duodenum, by an extensive burn on the chest, as an example of sympathetic irritation.

Dr. Milner Fothergill called attention to the value of bromide of potassium in allaying reflex irritation, and cited several cases in point.

Dr. Jagielski had noticed how spasm of the fauces, produced by their contact with the mirror of a laryngoscope, might be prevented by squeezing the lobe of the ear.

Monday, February 19th, 1877.

William Adams, F.R.C.S., President, in the Chair.

Mr. J. Knowsley Thornton read notes of a case, and showed specimen of

REMOVAL OF LARGE FIBROID UTERUS WITH OUTGROWTHS AND BOTH OVARIES; RECOVERY.

Mrs. H—, æt. 38, married seventeen years, but never pregnant, presented herself in September, 1877, complaining of an abdominal tumour. Menstruation had been regular, but always attended with much pain, scanty for two or three days. Had never suffered from any serious illness.

Four years ago began to suffer from inability to walk about, accompanied by general weakness. Eighteen months later she noticed increase of size, and a hard lump in the left side. This lump had been growing larger, and at the same time the pain in back, &c., had become so constant that she was unable to follow her usual domestic occupations, or to move about without assistance.

She was a native of London, but had resided latterly in Canada, where she had consulted many different doctors, who all told her any operation would be fatal.

On examination the uterus was found much enlarged, and was the lump complained of in the left side; there was also a large fibroid mass coming off from the right side at the junction of the body with the fundus; this mass filled up the pelvis, and was exceedingly tender to the touch, it was found impossible to raise it; uterine sound passed five inches into the mass in the left side of the abdomen.

The opinion of the Canadian doctors was coincided with, and the patient advised to try palliative treatment, with a course of ergot and iron, which she did from September till December, when she was getting worse rather than better, and urgently demanded operation.

She was taken as an in-patient at the Samaritan Hospital; and Mr. Spencer Wells, Dr. Savage, and Dr. Bantock, all at different times, saw her, with Mr. Thornton; all confirmed his diagnosis, and all agreed as to the danger of operative interference, though it was the only prospect of relief.

The danger having been fully explained to both the patient and her husband, Mr. Thornton at last consented to attempt the operation, thinking, if it was impossible to remove the mass, it might be possible to raise the tumour out of the pelvis, and fasten it to the abdominal wall with silver wire.

The operation was performed January 10th, at 2·30 p.m., Dr. Champneys administering bichloride of methyline, and Dr. Bantock assisting. Owing to the free hæmorrhage from incision in the abdominal wall, together with a dark foggy afternoon, Mr. Thornton accidentally pricked the intestine with the point of his knife, and the closing this with a fine silk peritoneal suture led to some delay, during which a good deal of intestine was forced out, and with difficulty returned after the incision had been extended from its

original length of four inches to five. Some difficulty was experienced in raising the pelvic portion, but it was at last accomplished by getting the other portion outside the incision, and using it as a lever. This left portion was then transfixed, and tied in two halves with strong string, the portions above the ligatures being cut away so as to give room to reach the root of the mass. The ovaries with their tubes were then successively removed, after transfixing and ligaturing each of their bases with double strong silks. There was a small cyst, of the size of a pigeon's egg, in the right ovary, which burst during its removal. The base of the mass, consisting of the cervix just above the vagina, was then transfixed and ligatured in the same way, and the mass cut away. Slight oozing following, one of the ligatures was made to encircle the whole, and tied tight. The pelvis was then well sponged out, and a sponge left in, while seven silk sutures were introduced into the abdominal wall; the sponge was then removed, coming out quite dry, and the wound closed.

The operation occupied rather more than an hour and a half. For the first forty-eight hours nothing but ice and barley water was allowed, and the patient had frequently, about every two hours, ℥xv of laudanum per rectum. The first night the highest temp. was 99·8°, pulse 92; at 7 the next evening the temp. reached 101·2°, with a pulse of 112, and the ice-water cap was put on. After this, by occasionally using the cap for a few hours, and then taking it off, temp. and pulse were kept steady, and the patient went on well, the opium being continued for a week, and then gradually decreased. On the 9th day after operation, some discharge per vaginam came on. On the 10th the bowels were troublesome, and the rectum was found loaded; warm oil injection, followed by simple enemata, relieved them. On the 13th day she had a bilious attack, which raised the temperature, and gave some little trouble; then all went well till the 24th day, when she had some fever, and a putrid slough was removed from the cervical canal, through which some ounces of fœtid pus followed. After this recovery was rapid, and she left the hospital for the convalescent home at Eastbourne on February 19th, a bright cheerful woman, having lost all the look of age and suffering which she had before the operation.

In some concluding remarks, Mr. Thornton claimed this as the first case in which the entire uterus had been removed along with the ovaries, leaving the ligatured stumps in the peritoneum. He had adopted this method from the success attending a similar use

of the ligature in ovariotomy, and he hoped the plan would have a more extended trial. Comparing it with other and extra-peritoneal methods, such as Wells' ovariotomy clamp, Kœberle's serre-nœud, or wire and pin, he claimed the advantage for it, that it was more universally applicable, and free from some of the disadvantages, such as secondary hæmorrhage on separation of the slough, which are known to attend them.

Dr. Godson, while congratulating the author on his unprecedented success, hoped that the brilliancy of it would not tempt other surgeons to undertake the operation unless the case were of so severe a nature that other measures were inadequate. Fibroid tumours of the uterus with outgrowths are not uncommon ; examples could be readily furnished where they attained enormous sizes, without producing very distressing symptoms. Such cases would not admit of so hazardous an operation as that described by Mr. Thornton. With regard to the after-treatment, the ice-bag to the head had in the case reported been frequently applied, and yet the temperature had never at any time been higher than 101·4°, and rarely had exceeded 100°. The ice-bag was little used outside the Samaritan Hospital. Mr. Thornton's experiences of its action would be very acceptable, if he would relate them.

Dr. Heywood Smith said there were three factors which ought to guide one as to operating :—(1) increase of size ; (2) increase of pain, making life intolerable ; (3) hæmorrhages. He had for years advocated the removal of fibrous tumours, though never as yet undertaken it. There were at the present time several patients attending at the Hospital for Women, whom he hoped to relieve in that way. He thought that, if the three factors mentioned were present in any case operative measures should be had recourse to, and to him division of the cervix, and subsequent enucleation, offered greater risk than the major operation by abdominal section.

Dr. de Gorrequer Griffith inquired how, as Mr. Thornton had failed to lift the mass from the pelvis, he had diagnosed that it could be removed by gastrotomy? He quoted a case in which at the autopsy the pelvic tumour was firmly adherent to the surrounding parts.

Mr. Richard Davy inquired whether the antiseptic treatment was ever adopted at the Samaritan Hospital? as in this case some measures of the kind were undertaken, contrary to what he had understood was the usual practice at that hospital.

Mr. Thornton, in replying, said he was glad of the opportunity of saying a few words respecting the ice-cap. He considered it of great value in the after-treatment; formerly it was only applied when the temperature reached 102°. This was considered a sort of danger signal. Now, however, on the principle that prevention is better than cure, as soon as the temperature is observed to be going up, the ice-cap is at once applied. By means of it the thermometer has been observed in less than twelve hours to fall from 106° to the normal standard. Where rapid breathing, with the appearance of acute bronchitis setting in, has occurred, the symptoms have all subsided after the ice-cap had been on for two hours. It reduces also rapidity of pulse, relieves headache, and persuades sleep when there is great restlessness. It thus appears rather to act on the nerve centres than to owe its efficacy to cooling the volume of blood.

Dr. Charles R. Drysdale then read a paper on

SYPHILITIC PHTHISIS PULMONALIS.

The writer remarked that, among ancient authors on the *Morbus Gallicus*, the expression "phthisis gallica," was often very loosely used, often signifying merely wasting due to the cachexia caused by syphilis, even where no lung affection was present. Syphilis frequently enough caused the appearance of ordinary tubercular phthisis in persons hereditarily predisposed to that disease, probably from its lowering effect on the general health and the nutrition of the system. What, however, he referred to as syphilitic phthisis was different from that. Syphilis had the power of acting on the lungs exactly as it acted on the other viscera, and of causing lesions, which produced all the symptoms of ordinary pulmonary consumption. As in the liver, the brain, the spinal cord, or the testes, &c., syphilis, when at its tertiary stage, four, five, or ten, twenty or more years after its commencement had the power of causing two forms of lesion, simple hyperplasia, or gummy tumour. The hyperplasia of the lungs due to syphilis, resembled that found in the liver or the testes, and which resulted from proliferation of the connective tissue in these organs, gradually going on to the destruction of the pulmonary tissue by smothering it, and ending in the lungs, as it does in the liver, testes, spinal cord, or brain, in sclerosis, the symptoms of which are so well recognised in all

these organs in cirrhosis syphilitica, syphilitic testes, sclerosis of the cord, causing either paraplegia, or even locomotor ataxy, and hemiplegia. It is rare that in the lungs any very great extent of the organs is attacked with this form of fibroid degeneration; but numerous autopsies of syphilitic patients have shown cicatrices, and thickening of the pleura, in the position of the sclerosed portions. Gummy tumours of the lungs were known to exist, and two well-marked specimens of these syphilitic lesions had been sent from Netley as a contribution to the debate on visceral syphilis at present going on in the Pathological Society of London. Such gummy tumours were like tubercles, subject, if unhealed, to soften, become expelled by coughing, and leave cavities, giving all the symptoms of the third stage of pulmonary phthisis.

Dr. Drysdale mentioned that he had had well-marked examples of these two forms in patients at the North London Consumptive Hospital. In one case, a man of fine muscular development, a navigator employed in coal-heaving, had been sent to Hampstead Hospital as suffering from phthisis pulmonalis, and with all the signs of a cavity in the apex of one lung. He was without phthisical ascendants in the family, but had a syphilitic history and tertiary perforation of the palate. Treated heroically with iodide of potassium, he regained health rapidly. Other similar cases were cited.

The diagnosis between ordinary or tubercular phthisis, and syphilitic, resided in the following points: tubercle has a predilection for the apices of the lungs; syphilis has its products indifferently in all lobes; tubercle attacks both lungs, syphilis *generally* only one; tubercle commits rapid ravages, syphilis is chronic, circumscribed, and usually solitary in its products. Tubercle causes, far more rapidly than syphilitic products, disturbance of the general health. As a general rule, tubercular patients, among hospital patients, live only about a year. Syphilitic cases are far more long-lived, and may become spontaneously cured and expectorate cretaceous masses in after years after the cavities heal up. The diagnosis is sometimes very difficult when no other symptom of syphilis is present. Hence the adage, *in dubio suspice venerem*, and, when the case is not clearly tubercular, as proved by hereditary transmission, configuration of chest, and the above-mentioned tests, it is wise to administer specific treatment by large heroic doses of iodide of potassium, ten, twenty, or thirty grains four times daily. This can

do no harm to tubercular patients, and may occasionally cure cases when no tubercle is present. Mercury, if used at all, for it is seldom of use in tertiary syphilis, should be used in very small doses, such as $\frac{1}{6}$th of a grain of the pure iodide twice daily, or $\frac{1}{3}\frac{1}{2}$nd of a grain of perchloride of mercury in decoction of sarsaparilla, according to the advice of Mr. James Lane, who much affects the use of sarsaparilla, a drug now of little repute.

The author of the paper explained that, when he used the term tubercular consumption, he referred to ordinary phthisis pulmonalis, being inclined to what was called the "unity" of that disease. He thought it now proved that, whenever catarrhal pneumonia existed, tubercular matter, although not always in the form of rounded adult tubercles, coexisted, and hence that catarrhal pneumonia deserved the appellation of tubercular. He quoted cases from Ricord, Alfred Fournier, Lancereaux, and others, to show the existence of true syphilitic phthisis, and, although he admitted that first-class authorities in England denied the existence of any such disease, he was convinced that he had seen several cases of it, and, in a few, that treatment by large doses of iodide of potassium had put an end to what might have otherwise proved a fatal disease.

Dr. Fothergill was afraid that the elaborate paper of the author would scarcely enable one to discover the means of ascertaining whether the diseased lung were of a syphilitic or tubercular origin. Could it be recognised during life it would undoubtedly be of great value. If syphilis was suspected the remedies should be appropriate. He objected to iodide of potassium, and always gave perchloride of mercury in combination with iron.

Monday, February 26th, 1877.

William Adams, F.R.C.S., President, in the Chair.

Dr. Thomas Churton (of Leeds) read a paper on

THE DESIRABILITY OF FORMALLY NAMING ANY EXISTING DIATHESIS IN CASES OF ACUTE DISEASE.

After remarking that the influence of diathesis or cachexia upon the course of acute disease is generally admitted, and names expres-

sive of such influence are even now given to some acute diseases (syphilitic iritis, gouty bronchitis, &c.), the author maintained that not seldom the influence, and even the very existence of a controlling diathesis, is either too little regarded, or altogether overlooked, for want of a constant, and specific recognition in nomenclature. Cases were related of various acute disorders connected with gouty, rheumatic, syphilitic, aguish, and other diatheses, in which no progress had been made towards recovery until these taints had been discovered and treated; and, on the other hand, examples were adduced of simple acute diseases—those occurring in previously healthy persons—which had been erroneously treated as if for a pronounced diathesis. Such errors would be less frequent, the author thought, if it were customary, or in a certain sense compulsory, to append to the name of the anatomical disease a second or adjectival name indicating the presence or absence, as the case might be, of any actively existing diathesis. This latter term was used in a wide sense to indicate any abnormal state whatever, and whether hereditary, or acquired of blood or bioplasm. If it were then urged if it be true that, in considering the question of treatment the constitution or diathesis of the patient is often of greater consequence than the anatomical disorder, does it not seem extraordinary to name the less important only, and not the more important also? Alluding to the restorative treatment of pneumonia, it was pointed out that Dr. Sturges had shown that the late Dr. Hughes Bennett did not employ it in nearly all his cases, but treated his patients according to their individual states—that is, he did not treat the pneumonia, but the diathesis or state of the patient; and yet, from the lack of any distinguishing adjective to show the difference existing between such patients, all of whom agreed, however, in the one circumstance of having pneumonia, they were in the end somehow or other grouped together as cases of pneumonia treated by a restorative plan.

The author concluded by saying, "The proposition merely is to extend to *all* a method of naming, already used in some cases of acute disease, a method which has the advantage of presenting to the mind in one view, not only the anatomical disorder, but also the chief abnormal characteristics of the patient."

Dr. W. M. Ord thought that he must be an exceedingly clever physician, or surgeon, who could always place the proper adjective before the disease of his patient; but, Dr. Churton's paper was

valuable as drawing attention to the necessity of setting to work in thinking about diseases instead of treating them in too trivial a manner.

Dr. Fothergill was of opinion that the paper clearly indicated the line in which young men of the present time should move; since he had seen gout in its wider relationships he had been able to cure his patients better. He quoted the case of a boy, suffering from unilateral chorea; observing that he had "Hutchinson's teeth," he at once put him upon mercury, and the boy got well rapidly. This is the last thing, had he not noticed the syphilitic taint, that he would have prescribed for an anæmic boy.

Mr. J. A. Bloxam observed that the author had only noticed in his paper subjects of a medical character. He believed that surgeons were in the habit of looking to the diathesis of the patient, and fixing the adjective implied by it before the name of the disease; for instance, there were *varicose* ulcers, *syphilitic* ulcers, and a host of others. He would like to hear from the author some better description of what is a strumous diathesis; from what he remembered of the nomenclature of diseases drawn up by the Royal College of Physicians, particular attention had been directed to the classification of the different diseases, *e.g.* there were many varieties of pneumonia under one heading.

Dr. Thorowgood considered Dr. Churton's ideas to be most important. Diseases must be treated after considering the character of the patient. In syphilitic anæmia iron was of no use alone, whereas perchloride of mercury would cure; and yet, according to theory, in anæmia mercury, by diminishing the red blood-corpuscles, is the worst drug that could be administered, while iron is the one directly indicated.

Dr. Robert J. Lee said that when in Paris he had been much struck with the lectures of Prof. Hardy, who bases his diagnosis on diathetic principles. He seemed to solve difficulties with a rapidity almost surprising. In his remarks he would point out with regard to eczema on what the disease depended; the only danger to be apprehended was lest we should go back to the time when they were *solely* diathetics.

Dr. Hare said we ought always to look out for what used to be called the constitutional condition, which may guide our treatment. It is not always quite so easy to name the disease—to put the proper adjective—but we should always try to do it.

Dr. Edmunds considered that there is more in the eye of the shrewd practitioner, that by experience of disease detects at once how he should treat the case, than from all the scientific formulations.

Dr. Robert J. Lee exhibited an apparatus for the treatment of

EMPYEMA, ESPECIALLY IN CHILDREN.

He observed that, in bringing the instrument before the Society, the subject was one which required most careful consideration, from the fact that the cavity of the thorax, in which the purulent fluid accumulated, cannot yield to atmospheric pressure, as the walls of an abscess would, or a cyst in other parts of the body.

The operation, as usually performed with Dieulafoy's aspirator in cases of empyema, necessarily exerts considerable pressure on the surface of the lung, as well as on the costal walls. On removing the trocar an exhausted cavity remains, which has a constant tendency to expand; for, we may assume that the effect produced by the aspirator on the tissue of the lung is not permanent, though greater than on the costal wall. Thus, it generally happens that the operation has to be repeated, or the drainage tube has to be inserted, and retained, until the exudation of pus has ceased. In order to combine the advantages which are undoubtedly obtained by the use of the aspirator with those afforded by the drainage tube, Dr. Lee had arranged a cup in such a manner that it might be fixed to the thorax by atmospheric pressure, and at the same time cover the orifice of the drainage tube, which would just project from the thorax. By thus keeping up atmospheric pressure the lung would tend to dilate, and occupy its proper space. By attaching a small glass bottle, or ball, to the sucker the pus could be collected, and removed. The author gave two illustrations of the use of the instrument:—A child, æt. 7, where the cup was attached, and attended to, by the child itself in a short time; when it fell off, as it would do, in three or four hours' time, there was some distress produced, and the child appeared to obtain positive comfort by refixing the cup. Dr. Lee hoped further to improve the instrument, which was shown to the Fellows.

Mr. Maunder said that the instrument appeared not to prevent the admission of air into the pleural cavity; if this were so he would find fault with it at once. Empyema resembling chronic abscess elsewhere, he did not see why it should not be treated on general

principles by the aspirator, or by the old-fashioned trocar and canula. If it will not heal, make a very free incision at the most dependent part, let the air out, and not allow it to be pent up.

Dr. Dowse exhibited an apparatus for spraying out pyogenic cavities—the pleura in empyema, the bladder in chronic cystitis, lumbar abscesses, &c. It consisted of two india-rubber air chambers similar to an ordinary spray-producer, but the capillary tubes for transmitting the fluid to be converted into spray were contained in a silver tube the size of a No. 10 catheter. Dr. Dowse thought it a good means for bringing ulcerated, or pus-secreting surfaces, into contact with minute particles of a saturated solution of iron, chloral, or carbolic acid, where, of course, the ordinary spray-producer would be of no avail. Dr. Dowse had treated one case of empyema with the spray of ozone ether with very good results.

Monday, March 5th, 1877.

William Adams, F.R.C.S., President, in the Chair.

The second General Meeting for the election of officers and Council took place; the ballot was opened at 7.30 p.m.

The Hon. Secretary read the Report of the Council on the state and condition of the Society.

The Treasurer read his Annual Report, and

The Hon. Librarian read his Annual Report on the state of the library.

The several reports were received and adopted.

The ballot was closed at 8.30 p.m., and scrutators appointed.

The Hon. Secretary announced that the Fothergillian gold medal of the Society had been awarded to P. M. Braidwood, M.D. (Birkenhead), for his essay on "Pyæmia."

The subject for the essay for March, 1879, was announced to be "The General Paralysis of the Insane."

Dr. Edmunds then read a paper entitled

QUESTIONS SUGGESTED BY VEGETARIANISM, WITH PERSONAL EVIDENCE FROM VEGETARIANS.

In introducing the subject, Dr. Edmunds named a long roll of great men who had practised vegetarianism, and had given evidence in its favour. Instancing as typical vegetarians Pythagoras among the Greek sages, and Shelley among modern poets, he characterised the works of Shelley as among the few great works in the English language, and he referred to Pythagoras as the man who had first correctly interpreted our own solar system, had thought out the greatest of the fundamental propositions in geometry, and had accumulated in his own mind all the learning of the ancients. The physical powers, and endurance of vegetarians, being also beyond question, it was submitted that, in presence of such facts, the necessity for eating flesh had yet to be proved.

As to the food for which, *à priori*, man's stomach and teeth appear to be best fitted, Dr. Edmunds argued that the masticatory and digestive apparatus in man are pratically identical with those in the anthropoid apes; that man's teeth are unfitted for eating flesh, unless such flesh has been first softened by cooking, and that man is constructed for eating fruits, not flesh. Man, however, as we know him, is largely a product of the food upon which he may have long subsisted, and which will have induced functional modifications in the digestive apparatus. The practical question therefore seems to be—How far is flesh-food necessary for individuals, as we now have to deal with them, in sickness, and in health? The answer to this question, as Dr. Edmunds saw it, depended solely upon whether flesh-flood helped man to a longer and better life, or otherwise.

Deprecating all theories of diet, as practically useless in the solution of food-questions, Dr. Edmunds thought, nevertheless, that the principle of natural selection, and gradual evolution, would throw light upon the subject, and he said:

"Were a number of families compelled to live exclusively upon flesh-food, it can hardly be doubted that in the course of generations those individuals who proved incapable of subsisting upon flesh would die out, while the survivors would develop such physical modifications as would increasingly enable them to flourish as carnivora, and, as would *pro tanto* incapacitate them from living as frugivorous animals. Such carnivorous survivors, if relegated back

to a diet exclusively of vegetable origin, would doubtless undergo a reverse process of natural selection, those who had flourished best upon flesh probably dying out the first, while those whose digestive capacities most readily reverted to fruits, and farinacea, would survive, and again flourish as vegetarians. This doctrine would probably not hold out so far as to enable us to produce a tribe of horses flourishing upon beef steaks, or a tribe of tigers which would flourish upon cabbages, and it may well be surmised that in the struggle for existence those animals who are the most highly specialised in their digestive capacities are the first to perish, as the conditions to which they are exposed alternate from one extreme to the other. In fact, it may be that man's present supremacy over the whole kingdom of animal life depends chiefly upon his omnivorousness, and upon the flexibility of his digestive organs. Thus, the capacity to exist upon flesh, upon fish, upon fruits, upon farinacea, upon roots, upon grubs, or even upon infusorial clay, obviously enables man to cope with hardships and to float over barriers which in the struggle for existence have long since excluded those vegetarian mammoths of which now fossil forms alone remain. One more century also will see out the great land carnivora, unless farms for producing lions and tigers become established upon the same basis as those which have already granted a new lease of life to the elephant and to the ostrich. Indeed, it would seem that man is destined to extinguish all animals which are not shielded by their subservience to his wants, by their own insignificance, or by the inaccessibility of their haunts. If that be so, man's final supremacy, and practical absorption of all animal existence into himself, will turn not upon the size of his brain, but upon the flexibility of his stomach. Only, when man alone remains for man to struggle with, will it be seen whether those who in the end survive their fellows do so by virtue of mental power, or of digestive capacity.

"Following out the train of thought suggested by the foregoing considerations, it would follow that, among dyspeptic sufferers, there may be many who fail in consequence of their power to survive upon flesh-food having been exhausted; and as a matter of observation I can testify that in a large number of dyspeptics a return to food almost entirely of vegetable origin is of great use. How often women, when nursing young infants, complain of toothache and are found to have teeth so soft that wherever the enamel is unsound

the ivory may be excavated with a penknife. Such women are generally found to have been subsisting largely on flesh-food, and beer, and their teeth decay simply because the system has been exhausted of earthy phosphates by the fluids that go to build up the infant's bones. Place such women upon a diet of milk and oatmeal porridge, and tell them to stop their beer, and to eat but little flesh, all the symptoms which are ascribed to hyperlactation will disappear, and the teeth are not then especially subject to decay. Other illustrations of specific forms of starvation will occur to medical men in which in respect to mere quantity there is no lack. To provide food containing such elements as will replace wasted tissues and furnish oxydizable matter for the supply of force, together with sufficient water for the chemical reactions and sewerage of the body, is the province of dietetics. It is obvious, also, that the ingestion of superfluous material in the way of food can only be a cause of obstruction to the system, and of premature destruction of those excretory organs upon which hangs the thread of life. But, beyond general principles, which cannot be practically applied so as to improve upon the guidance of a healthy instinct, we are quite at sea with regard to any further theory of diet, and must fall back upon mere empirical observation and analogy.

"Such being our position we have next to consider that animals construct nothing, that they merely act as condensors and store-houses of vegetable principles, and therefore that the only advantage to be gained by flesh-eating is that of making the body of an inferior animal a digester, intermediate between ourselves, and the crude vegetables.

"Were there no vegetables more nutritious than grass, it is clear that we should need the intervention of a ruminant stomach, either in an animal or in ourselves, and that those of us who could not develop such a stomach would perish. But, when we look at the fact that in fruit, and in grain, we have all the elements of food, even more concentrated than in flesh, it is difficult to prove any necessity for the intervention of an animal stomach under present conditions. Considering that the price of meat has been progressingly increasing of late, and that the problem for the masses of our people now is, how best to support a family on thirty shillings a week, I venture to urge that the expenditure of any substantial portion of such a wage in flesh, as compared with its expenditure in milk and oatmeal, and in fresh vegetable matter, must be a grave

mistake. It should also be remembered that a given quantity of land devoted to the production of cereals, fresh vegetables, and milk, will support many times the number of men that it will support if devoted to the production of flesh-food. With respect to the sick, I venture to submit that in our anxiety to sustain their strength we often poison them with nitrogenous material, and frequent observation has shown me that persons suffering from offensive breath may often be cured by abstinence from flesh and alcohol.

"I will now ask those gentlemen who have had experience in this diet to state shortly to the Society such facts as may have arisen from it, and to answer any questions which may be put to them.

"I have only to add that, though much impressed by observations of, and intercourse with, many eminent vegetarians, I have no experience to offer in my own person. In introducing the gentlemen who have kindly favoured us with their attendance this evening, it may be proper for me to state some personal facts which it would not occur to them to place before you, and I trust to have shown that there are some questions raised by vegetarianism which are of interest to us as medical men.

"The gentleman who will first speak is Professor F. W. Newman, and though his name will be a sufficient introduction, I may perhaps remind you that, more than half a century ago, this gentleman was placed a double-first in the examination at Oxford, and won a fellowship at Baliol. The long period which has since elapsed has been spent by him in incessant professional and literary activity, and you will see him here to-night in perfect physical health, and with the splendour of his mind and memory undimmed. I have had the privilege of Professor Newman's personal friendship for a period of some thirteen years. When I first knew him he appeared to be breaking down in health, and he suffered from fœtid breath, an inconvenience which then deeming it incurable I did not call his attention to. All the medical advice which he received was to take more flesh in his food, and the more flesh he took the worse he became, until, under the influence of some vegetarian friends, he left off flesh altogether. Since that time his health has vastly improved, and now, after some ten years' life as a vegetarian, he looks to me younger, and healthier, and stronger, than he did ten years ago, and the fœtor of breath has entirely disappeared. Professor Newman is now the president of the Vegetarian Society.

"The next gentleman will be Mr. Edward Maitland, also a

member of the University of Oxford, a gentleman who will be well known to you as an author, and whose experience in vegetarianism for some years entirely bears out that which I have described in connection with Professor Newman.

"There is also, in addition, the personal experience of Mr. George Sibley, a gentleman who has followed an active profession, as a civil engineer, and has worked hard in various parts of the world. Being just now in Spain, he is prevented from being here this evening, but his brother, our well-known confrère Mr. S. W. Sibley, will state his experience. Perhaps I may say that Mr. Sibley is a man of high mental and physical development, and in most vigorous health."

Prof. NEWMAN said—"I shall be seventy-two years of age should I live till June. I have been a teetotaller since childhood, and a large proportion of my good health I attribute to that. My digestion was never good. My weight has never raised since I was sixteen years old, always being 5 lbs. under 10 st.; from this I presume that digestion was complete, though difficult. I was always thin in the face, and pale. Some years ago there was a cattle murrain, and the price of meat was very high, and wishing to impress upon the artisans that flesh food was unnecessary, and that a vegetable diet would equally support strength and contribute to the nutrition of the body, I decided to adopt this system of diet myself, knowing that otherwise my words would have but little influence. I had very little faith that it would succeed with me, for I had been ordered to take meat twice daily. I left off meat quite abruptly, and soon found that I had no cravings after the flesh, and my digestion improved. I soon got to prefer the new dishes, for a great part of the flavour attributed to meat depends upon its accompaniments; for instance, I gave a friend lately a crumb omelette, and he thought it was veal. I found also that I could do with less quantities of food, which I believe to be due to all which I take being digested. I do not abstain from milk, and eggs; pea broth I consider far superior for nutrition to mutton broth. My breakfast probably consists of yesterday's potatoes fried up with a little onion; with this I take brown bread, plain or toasted, a little butter perhaps, and one morning probably out of five an egg. I take three meals a day, but two only are recommended, and I believe I am better when I omit the third. My bodily, and my mental strength, appear to have been unaffected by

the change in diet. I walk now at least three miles a day without fatigue. I generally employ my mind actively about eight hours each day, and can work as vigorously as I ever could. As a boy I always suffered from obstinate constipation. The day, however, I gave up meat I gave up doctor's pills. I have never suffered from diarrhœa, nor from any irregularity of the bowels, and the evacuations are of a remarkably wholesome character."

Mr. MAITLAND said that three years ago he found himself breaking down in health altogether; he could not walk a mile without feeling tired, and could do nothing unless he had ten hours' sleep. He had previously led a very active life, and had been a great traveller; he had been over nearly the whole of the world. While suffering from this state of extreme debility he fell in with friends who were vegetarians, or rather non-flesh eaters. They held that man is intended and constructed to attain his highest perfection, which does not depend upon shedding the blood of anything; and that he is not intended to stoop for food like animals, but can gather in the upright posture all that is within his reach. Thus, it would appear that we are really frugiverous, and seminivorous animals. When this argument was placed before him he liked the idea; it seemed a beautiful conception of existence, and he determined to try and follow it. He could not give up meat all at once, but after a few months he lost all desire or need of it. He lost flesh, but gained strength, and required no more than six or seven hours' sleep. He lost the tendency to constipation, which had previously been to him a great source of trouble. He became a different man; perception became so rapid he could almost see what he thought. At the present time he appeared under very trying circumstances, for up to a fortnight ago he had been working for two months from fifteen to eighteen hours a day, having only five or six hours' sleep; this was in order to complete a work for the press. His physical strength was such that he could walk almost any distance now without fatigue. The diet consists principally of fruit and cereals; biscuit and apples would be sufficient in themselves. If he takes an egg it is because there is nothing else to be had. All disposition for stimulants has gone, and he believes that the craving of drunkards would be rapidly cured by giving up flesh-eating. Finally, on religious grounds, after careful study, he had found that the whole of the religious founders of the world aimed at forbidding the diet of blood.

Dr. HARE would suggest whether the abstinence from alcoholic drinks had not exerted a most important influence on the improvement in health. He asked how many meals Mr. Maitland took daily, and the chief food eaten.

Mr. MAITLAND replied that he was compelled to take three meals, two not sufficing. The diet consisted chiefly of brown bread and butter, apples, grapes, figs, dates, and the like. He rarely touched an egg, and never took milk except to flavour tea.

Dr. CRISP said that Dr. Edmunds' statement, that the land of this country would afford five times as much if animals were diminished and we fed upon vegetable food, much astonished him. The animal and vegetable kingdoms were so intimately connected that, as every practical agriculturist knew, you could not have a good supply of corn without the use of animal matter. Nature had wisely ordered that the food required for man in different countries was generally provided for him. As regards the so-called vegetarians, they (most of them) were not vegetarians at all, they took milk, eggs, and butter; and as for the non-destruction of animal life, a man who fed on cabbages, or cauliflowers, destroyed ten thousand times as many animals as one who ate an ox. Dr. Crisp thought that we all took too much animal food, but there was a great difference between moderation, and total abstinence. It was necessary to take a wide, and comprehensive grasp of this system. The few examples adduced might be found under any system of diet. He might mention a case of a gentleman living near to him who had been thirty-five years a vegetarian, and about twenty-five years a total abstainer, but, although he called himself a vegetarian, he ate eggs, milk, and butter. This gentleman, who was 88 years of age, Dr. Crisp attended last year during a severe attack of typhoid fever, and he perfectly recovered.

Dr. THIN said that some years ago he spent a week in the Sacred Isles of the Eastern Archipelago. On one of these the priests live entirely on vegetables, and upon close inquiry he found that this was strictly the truth. Labourers were engaged from other islands, and they were obliged to conform to the same rule. The priests were chiefly men of a very low type of development, but a certain proportion were remarkably strong, both mentally and physically. He observed also how many there were who had attained a great age. There was one remarkable fact regarding flesh-eating, that among the Chinese, if a man eat opium in excess he can get along

perfectly well, providing he takes three meat meals a day, but directly he diminishes the amount of flesh food he commences to waste, and soon utterly sinks.

Dr. Milner Fothergill considered that the question of animal diet must necessarily before very long become an important one, for unless we do dry up, or go into the sun, as some suppose, all the animals will be consumed, and we shall be obliged to take to vegetables. It was certainly probable that a vegetable diet would have the effect of quieting the mind, for it was a common punishment to put refractory boys on bread and water, and if nothing else would tame them this would very soon bring them to their senses.

Mr. S. W. Sibley said that he had a brother, a civil engineer, who for thirty years had given up flesh-eating; out of these he had passed twenty years in India, or in travelling about during his leave, and he had been a great traveller, for he had visited almost all parts of the world. With regard to his physical strength, having accompanied him on a tour, he could testify that, after walking twenty to thirty miles a day with a good deal of climbing, his brother was by far the better man of the two. The amount of intellectual work he has done is also very remarkable; indeed, he has proved that the greatest mental and bodily activity may be attained on this diet. The principle he has taken up is that of not destroying animal life. He takes abundance of milk, no eggs, cheese occasionally. Leguminous vegetables always form a staple dish; of wine and other stimulant he takes none, or very rarely a little claret much diluted with water.

The further discussion of this paper was adjourned until Monday, the 12th inst.

Thursday, March 8th, 1877.

William Adams, F.R.C.S., President, in the Chair.

The dinner of the 104th Anniversary of the Society was held at St. James's Hall, Regent Street, and the attendance of Fellows and guests was the largest on record.

The Fothergillian Medal was given to the successful competitor, Dr. P. M. Braidwood, of Birkenhead, and

The Silver Medal of the Society to Mr. Richard Davy, the retiring secretary.

Monday, March 12th, 1877.

George Buchanan, M.D., F.R.C.P., President, in the Chair.

The President made a brief opening address, of which the following is an abstract:

After thanking the Society for the honour they had done him, he adverted to the comprehensive nature of the work of the Society, showing how it had always held itself to be concerned with the whole range of medical knowledge, and not with this, or that particular branch of it.

The Society had escaped the tendencies of that school which had regarded medical science as ending with the observation of facts, and which cared little for the interpretations of its observations, and little for the application of science to practice.

Among the earliest promoters of the Society were to be found men of equal eminence as anatomists, and as practitioners. Moreover, it reckoned among its earliest Fellows the greatest of all sanitary physicians; and to this high idea of a "Medical Society" this Society had remained true.

It had aimed at including in its ranks all medical workers knowing the mutual interdependence of each branch of medical knowledge upon the other, and the unity of the object to which all were directed.

The President concluded by pointing out the manifold aspects, physiological, therapeutical, and sanitary, under which the subject about to be discussed deserved to be regarded.

Dr. Lawson then opened the adjourned discussion on Dr. Edmunds' paper on

VEGETARIANISM.

He objected to Professor Newman, Mr. Maitland, and Mr. Sibley,

being considered examples of pure vegetarianism, as they all at times partook of eggs, butter, and milk. They were simply non-flesh-eaters. He then compared the anatomy of the carnivora with the herbivora, and contrasted their formation with the structure of man. As to the argument about the taking of animal life, he considered that it had been too strongly dwelt on by previous speakers.

Dr. DRYSDALE said that the observations of Dr. Edmunds as to the possibility of feeding a larger number of people by adopting this diet could not be accepted without certain resources. He quoted Ireland as an example, where the staple food in many parts was potatoes. If animals were not destroyed they would be competitors with ourselves for existence. He had no doubt that flesh-eaters were capable of greater endurance, and contrasted the English navvy with the French labourer, who mainly lived on soup and vegetables. He considered vegetarianism fulfilled certain requirements of disease, instancing especially the treatment of gout, and mentioned cases bearing on that subject. It was, in his opinion, not necessary for vegetarians to take eggs and milk, as he personally knew many people who abstained completely from these.

Dr. G. DE G. GRIFFITH scarcely thought the two cases quoted by Dr. Edmunds were appropriate, as both the gentlemen had become vegetarians owing to failure in their digestive powers, and he was not surprised that Mr. Maitland, who had been a hunter, and then became, as it were, a student, could not digest with comfort the same amount of animal food as before.

Dr. ROUTH objected to vegetarianism on the ground of the almost total incapacity of digesting starch in early childhood, and mentioned that in every instance all were carnivorous at first. Herbivora took milk from the mother; birds ate worms, caterpillars, grubs, &c.; in fact, without such an arrangement of nature no development could take place. He mentioned a case of aggravated dyspepsia brought on by an almost purely vegetable diet, which was cured by the use of raw meat, and stated the advantage of such treatment in diarrhœa among children. It was his opinion that vegetable-eating men had not the power of mind, brain enduring, as the animal eaters, and he mentioned the diet he would take after a hard day's brain work himself. He would ask Sir Joseph Fayrer the effects of vegetarianism on the virile powers of the natives of India.

Sir JOSEPH FAYRER considered the diet of man should be a mixed one, but said he had seen numbers of the natives of Northern India

who were pure vegetarians, and they were both physically and mentally equal to any existing elsewhere. In these provinces they lived chiefly on pulse, which, containing a large amount of nitrogen, would account for this. In Bengal, perhaps, the natives were not so fine, nor their strength so enduring; they lived there chiefly on rice with a little fish. No change of diet was found to be necessary among the European troops; and in reference to Dr. Routh's question on the virile powers of the natives, it was rarely prolonged beyond the age of forty, but he was not sure that this was due alone to vegetarianism, but probably to vicious habits contracted early in life.

The PRESIDENT then, in the absence of Dr. Edmunds, summed up the discussion, saying that Dr. Edmunds had made out a case for the trial of a vegetable diet under certain circumstances. Age was a considerable element, for children could not take the same food as was sufficient in riper years. Climate, again, had to be taken into consideration, and he compared the Greenlander's life with that of people in hot countries. He thought that an almost purely vegetable diet was useful in the treatment of some diseases, and stated that no doubt all the Fellows had noticed the advantage of such treatment in their practice. In conclusion, he said what we had to advocate was care and temperance rather than abstinence, especially avoiding excess in animal diet. He thought that the thanks of the Society were due to Dr. Edmunds for bringing the subject forward.

Monday, March 19th, 1877.

GEORGE BUCHANAN, M.D., F.R.C.P., President, in the Chair.

MR. HAINWORTH showed a specimen of

DISEASED OVARIES AND UTERUS,

from a patient, æt. 50. The peculiarity of the case was the persistent and acute pain referred to the region of the liver, which was treated with subcutaneous injection of morphia; the right leg became greatly swollen a few weeks before death. At the post

mortem fluid was found in the abdominal cavity ; lymph in patches was found over the ovaries and uterus ; both ovaries had cystic formations in them, especially the right. In the body of the uterus was a hard cretaceous mass. Mr. Hainworth concluded that the swelling of the right leg was caused by the pressure of the large cyst in the right ovary on the common iliac vein, and asked the Society if the mass in the uterus was a spontaneous cure of a fibroid tumour, or a new deposit.

Dr. Routh saw nothing important in the case, and asked if a vaginal examination had ever been made during life. He could see no connection between the pain referred to the liver, and the diseased condition of the ovaries and uterus. With reference to the mass in the uterus it was nothing more than the calcification of a nucleated fibroid tumour, which was very common, especially in barren women.

Dr. J. Braxton Hicks then read a paper on

THE VERY FREQUENT CONNECTION BETWEEN ECZEMA AND DIABETES MELLITUS.

The author called attention to the direct symptoms of diabetes, being irritation of the vulva in women, the orifice of the urethra in men. This fact has been pointed out by Pavy, Dickinson, and others, but he wished it to be understood that among females in cases of true general eczema, in a very large majority, distinctly pronounced diabetes also existed. It may be that in persons predisposed to eczema the saccharine urine is more especially irritating. Blood laden with sugar most probably is so, and all pathologists incline to the opinion that both diseases are dependent on neurotic states. The practical value of this knowledge is that, in treating cases of eczema, we should inform ourselves whether diabetes is not coexistent. The author then spoke of his own plan of treatment. He generally gave codeia twice daily ; this remedy seems to have a direct influence in allaying irritation. He has also given bark with arsenic and other tonics, according to the condition of the patient. The author then quoted two cases of females suffering from severe eczema occurring at the climacteric change, in neither of which diabetes had been treated for, but in both he had been able to afford great relief to the sufferers by doing so. He was confirmed in his impressions by Trousseau, Dickinson, and his own experience

showed him a very frequent association of the two diseases. His object, more particularly, in bringing this subject before the notice of the Society was to direct attention to the association of diabetes with general eczema, in order that our knowledge may be made more definite in the matter.

Dr. Lawson said it was interesting to find that sugar was secreted in these cases; it was not, however, always so, as he had a similar instance to those related by Dr. B. Hicks, in which such did not take place; it was very obstinate, and was treated for three or four months in the ordinary way with no good result. The eczema was cured after a few applications of collodion flexile.

Dr. Simms asked, as he said he had found good results follow from the application of carbolic-acid soap or simple borax lotion, whether these had been tried.

Dr. de Havilland Hall scarcely advised codeia to be tried, as he saw no advantage from it to opium, which he had found to be very serviceable.

Mr. Astley Bloxam asked the amount of sugar secreted, and also how much urine was passed in these cases per diem, as he had seen several cases of eczema with intermittent saccharrhæmia.

Dr. Edward Hicks said that in some of the cases related by his father the patients had passed as much as six pints daily; the specific gravity was always very high, and the amount of sugar tested by Pavy's solution very large. He would ask the Fellows for information where a cheap diabetic food could be obtained.

The President briefly thanked Dr. Braxton Hicks for his communication, inquiring whether any observations had been made by him to determine the presence of sugar in the eczema of children.

Dr. Lauder Brunton then read a paper on

ARSENIC IN THE TREATMENT OF ALBUMINURIA.

The author divided albuminuria into two sorts—true and false. He did not restrict the term "false albuminuria," like Gubler, to those cases where the presence of albumen in the urine depended on the admixture of pus or blood, but extended it to all cases where an albuminous body other than serum albumen appeared in the urine. It thus included the cases where egg albumen appeared in the urine after several raw eggs had been eaten. False albumi-

nuria might occur without any alteration in the structure of the kidney, or in the circulation through it, the albuminous body being simply secreted like urea or salts. Under true albuminuria he included those cases only where serum albumen appeared in the urine. It might depend on the alteration in the structure of the kidney, or on disturbances of the circulation, leading to the congestion of the capillaries, and venous radicles of the organ. He narrated a case where albumen had occurred in the urine for nearly nine years. It appeared after work, either mental or bodily, and was absent during rest. It also appeared after the use of meat or fat for breakfast, and disappeared when a farinaceous diet was adhered to; after midday the patient was able to do much more work, and could indulge in meat or fat without ill-effects. The apparent connection between the digestion, and the appearance of albumen in the urine, led the author to consider the case one of false albuminuria, the albumen probably being due to pancreatic juice having dissolved, but not thoroughly digested, the albuminous constituents of the food. The appearance of albumen after fatty food he believed to be due to acidity of the chyme interfering with pancreatic digestion. He was inclined to believe that the kidneys also were not quite healthy. Quinine greatly increased the albumen. After many remedies had been tried, Liq. Arsenicalis in doses of ℥iij was prescribed, and this was successful. When the medicine was discontinued the albumen returned. Liq. Sodæ Arsenicalis also stopped the albumen. Pancreatic emulsion proved injurious, but pancreatin caused the albumen to disappear, though it had not been used for a sufficiently long time to show whether or no it was likely to prove permanently beneficial.

Dr. G. de G. Griffith mentioned that he had seen several cases of true and false albuminuria, and mentioned them in detail. The most remarkable was that of a woman operated on for fistula in ano, in which great irritation, with symptoms of uræmic poisoning, was present, followed by albumen in the urine whenever the wound was dressed; the albumen disappeared when the wound was left alone, but reappeared on redressing. She ultimately recovered.

Dr. Lawson complimented the author on his paper, and asked if any difference was present in the circulation of the patient in the morning and in the evening, as this would cause an alteration in the amount of albumen secreted.

Dr. Wm. Ewart asked the author whether, in the two morbid

conditions of the kidney, with which albuminuria was most commonly associated, namely, the granular kidney and the large white kidney, his mechanical theory of albuminuria was capable of being reconciled with anatomical facts. In the large kidney of tubular nephritis pressure would be evenly spread over all the constituents of the kidney; but in interstitial disease the unprotected secondary capillary network would presumably suffer more lateral pressure than the capillaries in the glomeruli.

Mr. Hainworth said he had been a student under Dr. Bright, and had seen cases of albuminuria and a great variety of treatment employed; in some compound jalap powder had been most efficacious, in others tartar emetic, and in the third class sulphate of iron and sulphate of magnesia. He did not feel inclined to be taken by the treatment of albuminuria by arsenic, and should hesitate to employ that drug.

The President said he hoped we should all read the paper in the 'Proceedings' of the Society, as it would help us to appreciate the distinction spoken of by the author as separating false and true albuminuria, and he asked if the author could furnish any practical test, or chemical decomposition, to demonstrate the quality of albumen in the two classes of cases.

Dr. Lauder Brunton replied to Dr. Griffith, and considered the case he had mentioned was of very great importance, as it was the only one he knew of in which a reflex action had produced albumen in the urine. To Dr. Lawson, he had been unable to make the observation about a difference in the patient's circulation, as he was only able to see him between 12 and 2 o'clock in the day. To Dr. Ewart, he would say that he had but one doubtful point in his mind, about the actual anatomical changes in the granular kidney, and he was not certain as to which order he should classify such cases. To Mr. Hainworth's observation, he was not aware of the advantage to be derived from tartar emetic, as employed by Dr. Christian. Should arsenic not have succeeded he would have used phosphorus, and then antimony, as they are much allied.

Monday, March 26th, 1877.

George Buchanan, M.D., F.R.C.P., President, in the Chair.

Dr. G. de G. Griffith then read the following case of

DISLOCATION BACKWARDS OF THE HEAD OF THE HUMERUS ON THE DORSUM SCAPULÆ.

"The accident is very uncommon, and, therefore, this, which occurred to one of my patients, is, I think, worthy of putting on record. A case has recently been reported in the 'Lancet' (February 3rd, 1877) as having been treated in the Hôpital de Lariboisiere, Paris, by M. Tillaux, making his second, he having had another in 1867, and the reporter mentions that Sir Astley Cooper related six cases; Malgaigne two. M. Sedillot, in 1834, showed a case which had been mistaken for a fracture of the scapula. In Sir A. Cooper's cases reduction was easily effected; in this, which happened in my own practice, reduction was difficult.

Mrs. T—, æt. 60, of a very stout habit of body, was coming down the stairs to go to church on Sunday morning, having just put on a pair of new boots with heels higher than ordinary; she was near the end of one flight, was preparing to step on the landing, overlooking that there was another stair, when the heel caught in the stair-carpet; she missed her step, and fell violently against the wall, the front of the shoulder bearing the brunt of the blow, as she swung round with the impetus of her own stepping-forward motion and her own weight, which was no small one.

The pain was considerable, and rendered her faint, and when she was removed to her bedroom she found something wrong with her arm. I was sent for, and after having made a careful examination, I found an infra-spinous luxation of the humerus.

The grounds of diagnosis were inability to move the arm in its usual manner, altered appearance of the shoulder, owing to the absence of the head of the bone from its socket, though the altera-

tion was not very noticeable, the patient being stout. The chief points of deformity were, that the shoulder looked as if it had been dragged backwards and nearer the spine, and was held in that position; that the acromion end of the clavicle was prominent, while the edges of the fingers were able to be put in a depression beneath it; that the axillary space was almost obliterated, though the head of the bone could not be found in it; that there was on the dorsum of the scapula a projection which, by grasping the arm and moving it, was ascertained to be the head of the humerus lying under the spine of the scapula; the elbow projected from the side. Dr. Quain, having been in attendance upon the lady in a former illness, was also called in, and on his arrival he confirmed the above diagnosis, and stated that he had had a similar case before.

According to appointment we met, and by means of pulleys reduced the dislocation. The cause of this form of dislocation was said by Sir A. Cooper to be a blow on the front of the shoulder at the same instant that the infra-spinous muscles contracted, and helped to jerk the bone into its unnatural position. Nélaton considered that direct anterior force was the cause of it, and M. Tillot's opinion was that it might result from torsion. There is little doubt but that direct anterior violence, torsion of the body, and displaced arm, aided by striking the elbow against the ground or the wall, and possibly spasm of the muscles dragging backwards the head of the bone contributed to the production of the displacement. It was some months before the lady recovered the use of her limbs.

Mr. A. C. Routh then read a case of

MALIGNANT SMALLPOX.

The subject was a woman, six months and a half pregnant, primipara, who, as first symptoms, presented slight backache and headache, unattended by nausea or pyrexia, followed by a general rash similar to that of variola.

Premature labour took place a day later, attended with little post-partum hæmorrhage. After complete intermission, lasting about forty-eight hours, of the pain in the head and back, the pain in the back returned with terrible severity, situated just above the sacrum, lasting about fourteen hours, but ultimately yielded to morphia (turpentine steeps being locally applied). After a fair night's rest, copious hæmaturia, and bleeding from the stomach,

lungs, and vagina occurred, (the lochia having been previously suppressed). The patient at the onset of these hæmorrhagic symptoms had a full and strong, but quick and uneven, pulse, and respirations were heaving, quick, and irregular. The skin was throughout moist and cool. About three hours after the first evidence of hæmorrhage, patient died, having shortly before this a general convulsion, and developing on abdomen a few scabs, about one third of an inch in diameter, containing some discoloured serum, and some blood.

Treatment.—Turpentine, ammonia, amyl. mucil., and atropine.

The points of interest about the case were the diagnosis, rendered somewhat doubtful by (I) absence of pyrexia; (II) normal pulse throughout, excepting acceleration during post-partum and general hæmorrhages; (III) complete intermission of backache, taken with (IV) absence of nausea and epigastric pain; and, lastly, the rash, which disappeared entirely from the face, and partially from the extremities, on the third day of its appearance. (The patient was said to be very subject to rashes, and to have had one exactly similar to the present three months ago.) Post mortem was refused.

Dr. EDMUNDS said, in reference to the non-development of the usual symptoms in this case, it was to be accounted for by the absence of the power to cope with the disease in the patient, as is the case in typhus fever, where it would appear to produce all the phenomena of the complaint it is necessary to have strength to fight the disease; for in many cases the patients die struck down by the enormous quantity of the virus received without a struggle, developing no regular order of symptoms. He asked if the patient had ever exhibited a hæmorrhagic tendency previous to this attack.

Dr. ROUTH saw this case when *in articulo mortis*, and it was quite obvious to his mind that it was one of malignant smallpox, and could not be compared with purpura hæmorrhagica. The author had not mentioned that there had occurred two cases of smallpox in the house previously.

Dr. BUCHANAN said it would be interesting to know if smallpox occurred in the house subsequently to this case; had the patient been revaccinated or not?

Dr. ROUTH replied, saying that the woman had not been vaccinated since childhood. Three months before she was taken ill her younger sister had smallpox, and for ten days was in danger of her life. Twelve days after, a brother had the disease, was removed to

the smallpox hospital, and died there. In answer to Dr. Edmunds, her previous health had always been perfect. He was not able to account for some of the symptoms in her case, but probably Dr. Edmunds' hypothesis was correct.

Dr. DRYSDALE then read further observations on

ANIMAL VACCINATION.

The author said he considered it a great honour to read a paper on this subject in a Society which had once numbered Dr. Edward Jenner among its Fellows. He was much in favour of state compulsory vaccination, but remarked that in its present form in this country there were two or three weak points in it. First of all, came the fact that in times of epidemics of smallpox it was really very difficult for practitioners to obtain enough lymph to vaccinate and revaccinate their patients. Next, syphilis had been spread certainly, occasionally, from apparently healthy infants to numbers of really healthy infants and adults. These were the two main difficulties, but in addition to these there was the fact that long humanised lymph certainly sometimes (according to Dr. Martin, of Boston, once in 500 cases) caused erysipelas. Besides which, it was the opinion of many excellent vaccinators that the long-continued passing of vaccine matter through human beings had much weakened its protective power against smallpox. The use of animal vaccination as practised in Brussels and in Boston, U.S., was at any rate entirely free from the first two of these objections. In times of epidemics an unlimited supply of pure vaccine lymph could at once be obtained by the simple practice of inoculating a large number of calves, so that if 50,000 patients wished to be vaccinated they could all be supplied with a properly conducted animal vaccine, and taken in perhaps a week. Syphilis, too, of course, could not be conveyed by a calf to a human being. With regard to erysipelas, Dr. H. Martin, of Boston, U.S., stated to Dr. Drysdale in a letter (February, 1877), that out of 1,000,000 persons vaccinated with animal lymph in the States, not one case of erysipelas had occurred, whilst it is not so very uncommon in England for infants to be severely affected with it. The result to the infant of animal vaccination is very different to the ordinary vaccination; the scab is umbilicated, and the vesicle does not rupture. Dr. Martin also alleges that in no single case where he has successfully vaccinated

or revaccinated a person in adult life has smallpox ever once been known to attack the patient. Since the author wrote on this subject in January, 1877, several successful attempts have been made in this country to inoculate calves, and he hoped the Government would encourage the practice, so promising in every way, by a grant for the purpose.

Dr. Wilson, of Alton, stated that he was a public vaccinator, and had seen the bad effects that followed the use of humanised vaccine. He was so impressed with the advantage of virus procured direct from the calf, that he was determined to employ it when the opportunity occurred; this happened lately, and he then sent to Dr. Warlomont, Brussels, for lymph, and obtained a supply. He procured a young heifer calf; having shaved from the umbilicus to the udder, he introduced the lymph into eight or ten punctures made with a lancet. On the third day redness around these punctures was apparent; on the fourth unmistakable signs existed; two or three pustules had coalesced, and on the fifth day they were fully matured. He then took 110 points, and on the sixth day over 200 more, also some lymph on glasses, and subsequently he removed the scabs. He brought some of this lymph with him, which was at the service of the Fellows.

Mr. Brudenell Carter said in 1869 heifer vaccination was introduced into London by Dr. Blanc. He had a child then which he had not been able to have vaccinated, as he could not obtain what he called pedigree-lymph; as he did not wish to defer the vaccination longer, he took the child to Dr. Blanc for vaccination from animal vaccine. It was punctured in five places; the vesicles were perfect, although a third larger than the ordinary ones; the constitutional symptoms were not severe; the marks are large, and remain good. Dr. Blanc told him that his success was the same in all he vaccinated.

Dr. Crisp said he had read a paper on this subject some time back on a commission that had been appointed in Paris; they had come to the conclusion that there was no direct advantage to be derived from this method; and they stated that the lymph did not keep so well. No difficulty ever existed in vaccinating cows, or calves. He mentioned a case in which twenty children that were unfortunately vaccinated from an erysipelatous arm, all had erysipelas, two died. No doubt several such instances had occurred.

Dr. Coby said he had vaccinated over 2000 with humanised

lymph, and also a few with animal vaccine obtained from Brussels; in one of the latter cases two vesicles formed, in another three, in a third four, which was a much smaller proportion to the punctures to what he obtained when using human vaccine. In all the vesicles were smaller, and the scars less. He gave reasons for regarding vaccinia as a modified form of variola, basing his views on the observations of Ceely, and others.

Dr. C. T. Pearce asked Dr. Drysdale whether he had read the report of the medical officer of the Privy Council on the subject. It was an account of Dr. Seaton's inquiry in Belgium on animal vaccination, and the conclusion he arrived at was, that heifer vaccination was unreliable, and frequently failed. The department of the Privy Council, of which Mr. John Simon was the medical officer, did not see fit to advise the adoption of heifer vaccination; and so far as he (Dr. Pearce) could learn the Local Government Board has not up to the present time recommended the adoption of animal vaccination in preference to the system practised at present in this country. Dr. Drysdale has certainly strong reasons for urging animal vaccination, viz. to obviate a danger now proved to exist, although a few years ago it was not accepted, that of inoculating with arm-to-arm vaccine, constitutional diseases such as syphilis; he would like to know what is the proper test of successful vaccination? Dr. Drysdale had spoken of great success in Belgium attending the practice which he so strongly urged; but this success can only apply to the production of a proper vesicle running its regular course. This, however, is no safeguard; the only real test of the protective of any lymph is the occurrence of an epidemic of smallpox, such as that which spread over Europe in 1871–73. From information he had received, collected from official sources in every country of Europe, he found that in three countries in which animal vaccination has been adopted there has been the most serious mortality from smallpox. In North Holland in 1871 the smallpox mortality was 500 per 1,000,000 living, in South Holland 10,000 per 1,000,000, in Utrecht 11,000 per 1,000,000, in the cities in Amsterdam the deaths were 7000 per 1,000,000, in Rotterdam 13,000 per 1,000,000, and the Hague 14,000 per 1,000,000. In every country in Europe visited by the late epidemic vaccination did not appear to check the mortality; indeed, in countries where vaccination had been compulsory for the past sixty years, there the smallpox raged with fury. In Berlin, where 90 per cent. of the

population are vaccinated, and revaccinated twice, the mortality was in the last epidemic two and a half times greater than in London in the height of the epidemic. In Sweden, called the best or "most vaccinated country in Europe," the mortality in the last epidemic was the heaviest in living memory. Yet these are the countries, Prussia and Sweden, specially referred to as instances of vaccination having stamped out smallpox. Drs. Seaton and Simon gave evidence before a Committee of the House of Commons in 1871, and both these gentlemen pointed to Prussia and Sweden as examples of the efficacy of vaccination as a prophylactic. A similar observation was made as regards Scotland, but when the epidemic reached there the results were as disastrous. In Edinburgh, Dundee, Leith, and Greenock, the death-rate ranged from 1400 to 3000 per 1,000,000 living. In France 1600 of the army, all vaccinated, died of smallpox. Thus, in every country, not even excepting Belgium, smallpox seized on vaccinated populations. He could prove that there was a general subsidence of smallpox about the middle of the eighteenth century; that the mortality was increased by the practice of inoculation; that at the abandonment of that practice smallpox abated; that the abatement was mistakenly attributed to the adoption of vaccination.

Dr. Edmunds proposed an adjournment until Monday, the 9th April. This was put to the meeting, and carried.

Monday, April 9th, 1877.

George Buchanan, M.D., F.R.C.P., President, in the Chair.

Mr. John Astley Bloxam showed two cases of primary chancre, situated on the upper lip of a female, æt. 27, and on the lower lip of another, æt. 20; in both all the characteristics of a syphilitic sore were present, together with enlarged cervical and submaxillary glands. The duration of both sores were about the same; both had been under medical treatment before applying at the Charing Cross Hospital. In the first case the sore was placed a little to the left

of the mesial line, having a raised circumference, with a flat, oval, ulcerated surface, and a distinctly indurated base ; the submaxillary glands on the right side were enlarged, nodular, and movable. In the other the sore was seen on the lower lip, a little to the left of the mesial line. Circumference raised ; no suppuration, but a slight weeping serous discharge existed from a circular abraded surface ; the whole lip was everted, swollen, and indurated, especially round the sore. Mr. Bloxam brought these cases forward, not as being rare from their situation, as many such cases have been reported, but that the Fellows might have the opportunity of seeing them in order to arrive at a correct diagnosis in like cases, as that is the greatest difficulty, for the history given is either imperfect, not reliable, or unavailable.

Mr. Royes Bell showed a photograph of a primary chancre, which occurred in a girl, æt. 18, contracted from a young man while nursing him ; he suffered from ulceration of the larynx, and was said to have died of phthisis. He also mentioned the case of a young lad, who had lately come under his care with a sore on the lip, with bubo on the left side of the neck. The father attributed it to his having drank out of the same cup as that used by the son of the master of the house, who was suffering from ulceration of the mouth, and cheek, of a specific character. Unfortunately this was not the end of it, for this young man was engaged, and had given a primary sore on the lip to the lady. She was also under his care.

Dr. Routh thought there was nothing rare in these cases, they were common in Paris, he wondered why Mr. Bloxam brought them forward unless for the peculiarity of their situation.

Mr. Francis Mason thought the Society indebted to Mr. Bloxam. It was not the rarity of their situation, but the importance of observing and making a correct diagnosis, the histories frequently given being so obscure. He mentioned a case which had been mistaken for epithelioma, and another in which two successive portions of the lip had been removed ; both were syphilitic, and were cured, as in these instances, when mercury was given.

Dr. John Brunton was pleased to see these cases, as being valuable for diagnosis. He mentioned the case of a carpenter, which had been under his care with a primary sore on the finger, the cause of which he could not account for.

Dr. EDMUNDS then opened the adjourned discussion on

ANIMAL VACCINATION.

Upon the remarks made by Mr. Brudenell Carter, he would merely say that he did not hold the same fear as he did of human vaccination. He had vaccinated over 500 cases, and three cases of erysipelas had occurred among them; two died. He did not lay the charge of erysipelas to the lymph used. He believed that such a percentage might occur after any scratch, or wound, under similar circumstances. He then gave the cases in detail. The first occurred in a poor feeble infant after vaccination, which also had typhoid symptoms. The second was in another feeble child, who slept against a wall, saturated from the damp which emanated from a dung-heap on the outside. The third occurred in his nephew. The lymph was taken from his daughter; she was healthy, and the vesicles were good. The nephew had severe erysipelas, and nearly died. The scars subsequently presented the appearance of those resulting from a burn, and differed from the pearly scars on the arm of his daughter. At the age of three he was vaccinated on the other arm; good vesicles followed, and the scars are pearly and good. At the age of fifteen he had smallpox; he is now quite well and healthy. His daughter has always been healthy, and had varicella at the age of twelve. As to skin eruptions following vaccination, three had only come under his notice, they were lichen-like. He did not attribute this to bad lymph. With regard to prophylactic advantages of animal over humanised lymph, he was unable to express an opinion; but in order that vaccination should be effective quantity must be exhibited. He then stated his mode of performing vaccination, and said he usually employed points, making scratches crossways half an inch long.

Dr. GORDON BROWN said he was a public vaccinator, and took a great deal of interest in the subject. He had lately been to Brussels and seen Prof. Warlomont's institution. It had a subsidy from the government, and was situated close to the Zoological Gardens. His reason for going there was the difficulty he had experienced in obtaining lymph during the last epidemic, and although he always took the greatest care to examine every child, before vaccinating, for evidence of hereditary syphilis being present, yet he never felt absolutely certain that it might not be; whereas, in using lymph procured from animals, such could never occur. He had tried to

vaccinate calves in this country, but had failed. He then described Prof. Warlomont's method of vaccinating a calf, and how he procured the vaccine. The calf was strapped on its back to a table, and shaved between the umbilicus and the udder; sixty punctures were made with the lancet; fluid lymph was blown over them. On the third day slight induration and redness around the punctures was observed, on the fourth vesicles were found, and on the fifth Prof. Warlomont removed the lymph, and said he never did so later than the seventh. His method of removing, and preparing the lymph, was as follows:—With a pair of forceps he ruptured the vesicles, thick clear lymph then escaped, which he collected with an ivory point on to a disc; it soon coagulated. He then added an equal part of glycerine and water to the same quantity of lymph, and stirred the two together, removing the fibrine, and a clear transparent fluid remained; this he stored in tubes, or on points. There were one or two clinical features. He observed (1) that in half an hour the lymph ceased to flow from the vesicles, unless the animal was placed on his feet; (2) that black calves were no use for procuring lymph from. He also saw children vaccinated with this lymph; no more inflammation was set up by it. The vesicles were perfect, in fact, no finer, but as good as he had ever seen obtained from humanised lymph. Considering the care the authorities take against any blood being present in the tubes or on the points which they provide, in case of the slightest chance of syphilis, &c., following, he strongly advocated the use of animal lymph thus obtained, as such dangers could not possibly occur.

Dr. Buchanan complimented Dr. Drysdale on the way in which he had treated the subject. He could wish, however, that he had had some other basis for his statements than Dr. Martin's publication; and with reference to these statements, first, as to erysipelas, he (Dr. Buchanan) pointed out that the term "erysipelas," as used by Dr. Martin, appeared not to include that severe irritative inflammation which admittedly in certain cases followed vaccination from the calf, at least as frequently as it followed human vaccination; that Dr. Martin's contention that "erysipelas" was actually less likely to occur after calf-vaccination, than after scratches with a clean lancet, could not seriously be maintained; and that the supposed evidence of humanised lymph being more frequently associated with that accident, than direct calf lymph, was based on a professed experience, in contradiction to the experience of the

National Vaccine Establishment. Secondly, as regard the danger of syphilis-production, Dr. Buchanan, if he admitted that syphilis had followed the operation of vaccination with humanised lymph, professed himself quite unable to apprehend the excessively minute risk of this occurrence, or to satisfy himself that where syphilis had really followed vaccination, the poison of syphilis had actually been contained in the vaccine lymph itself. So far as dirty lancets, or dirty fingers, or subsequent infection, accounted for any of the so-called syphilitic vaccinations, that risk would be run by children operated on with animal lymph equally with those to whom humanised lymph was used. Thirdly, as regards the alleged loss of protective power by lymph that had passed through various human systems, Dr. Martin's experience that he had never known a person to take smallpox who had been vaccinated with calf lymph after puberty, had to be compared, not with English experience of infantile vaccination, but rather with English experience of successful revaccination performed at or after the time of puberty; and the Society knew that in such persons the occurrence of smallpox was an extremely rare event. But though, for these reasons, the President saw no advantage in vaccination with calf lymph that was not equally to be had from vaccination with humanised lymph, he would be prepared to defer, as far as might be, even to the ungrounded wishes and fears on the part of those compulsorily submitted to the operation, and in that sense he should find a plea for animal vaccination. It must be a condition, however, of such concession that it should promote, or, at least, should not interfere with, the maintenance of such arrangements as were necessary for the supply at all times, and at all places, of fresh and efficient lymph for general vaccination.

Monday, April 16*th*, 1877.

George Buchanan, M.D., F.R.C.P., President, in the Chair.

Mr. Francis Mason showed a man, who is now under his care at St. Thomas' Hospital with a bronchocele. The patient was fifty-

two years old, and about twenty years ago noticed a small lump about the size of a filbert on the right side of the trachea. It gradually got larger, and until a few months previous to his admission into the hospital in July last, had caused little inconvenience excepting through its weight. At times, however, it caused dyspnœa by pressure on the windpipe, and he was anxious to have something done to relieve this occasional distress. On admission the measurement of the circumference of the tumour, taken round the neck, including the most prominent part of the growth, was twenty-three inches. It was no doubt connected with the thyroid gland, and was of a fibro-cystic character. Mr. Mason described the treatment he had adopted, which consisted of tapping one or two of the cysts, and injecting a solution of the perchloride of iron, of two drachms of the salt to the ounce, *i. e.* about double the strength of the tincture of the pharmacopœia. The injection of the fluid was followed by very severe symptoms; in fact, at one time he was in peril of his life. Subsequently, setons of lampwick were passed through the more solid portions of the growth, which diminished the size of the tumour, but the greatest improvement followed the use of a subcutaneous ligature, by which a slough came away. Mr. Mason showed a photograph of the patient before the operation, and the patient himself was present at the meeting.

Mr. William Adams said that he had noticed severe constitutional irritation follow the injection of perchloride of iron, more especially in some forms of nævi about the face; and although he had not had much experience in treating such cases described by the author, yet he could fully understand the severity of the symptoms set up, which in his mind were very serious, and went rather against the treatment.

Dr. de Havilland Hall said he had treated twelve cases of bronchocele with injection of iodine lately. No irritation followed when the solution had been injected into the cyst itself, but, if any escaped into the surrounding cellular tissue, great local irritation, with severe constitutional symptoms, was set up. He found the perchloride of iron most useful in the cystic form. With reference to the length of time these cysts continued to discharge, he stated in one case where some kind of fluid was injected it had been discharging for three years, and still continued to do so.

Dr. Routh did not presume to suggest any treatment to Mr. Mason, but said he had seen several such cases at the Cripples'

Home; they all, he found, yielded under constant blistering, with application of an ointment composed of equal parts of Ung. Iodi co. and Ung. Hydrargyri. He suggested that, perhaps, the injection of a strong solution of bromine, 1 to 5 pints of spirit, might be useful, as such was found efficacious in cystic tumours of the breast, and which never produced any constitutional disturbance. He said he believed the galvanic cautery might be found useful, and, indeed, he thought Dr. Althaus had mentioned the cure of such cases by these means.

Dr. DE G. GRIFFITH stated that Mr. Lennox Browne had shown several cases at the Harveian Society, which had been treated in a similar way to Mr. Mason's, but no alarming symptoms followed.

Dr. LAWSON said, in reference to the frequency of cystic disease of the thyroid gland, that out of 106 examinations he found 50 per cent. had some cystic formation.

The PRESIDENT said Mr. Mason was to be congratulated on his treatment of the case, as he would appear to have diminished the bulk of tumour in the proportion of 7 to 1.

Dr. CRISP said that bronchoceles frequently existed among the lower animals, especially among young racing colts; they were never seen among cart horses; he believed that this was due to what he termed the "forcing system."

Mr. MASON replied he had employed the electric current in this case without avail. He used it for nævi, but did not prefer it, as he had seen it produce shock.

Dr. CRISP then read notes of a case (and showed specimen) of tubercular disease in a hen, that had recently died in confinement, where the bird did not obtain the amount of animal food it would have procured if it had had a larger range. The specimen was exhibited in reference to the late discussion on vegetarianism, and he inquired what would be the effect of a vegetable diet in this country as regards the increase or decrease of pulmonary consumption, and of tubercular affections generally? He believed that such diet would tend much to the increase of these lesions, and he came to this conclusion, especially from the fact he had ascertained many years since, when examining the animals that died at the Regent's Park Gardens, that the animal-feeders were less liable to tubercle than those that fed on vegetables. Dr. Crisp stated that he had received information that the amount of tuberculosis now existing at the new monkey

house was the same as formerly; in fact, he objected to the present building.

Mr. Astley Bloxam said he did not think that any particular kind of food developed tuberculosis. He was more inclined to agree with Dr. Buchanan that the element of lodgment, especially sleeping arrangements, had to be taken into consideration. He mentioned the fact that recruits joining the household cavalry were a body of men found peculiarly liable to tuberculosis. These come mostly from the country, where they have had, before enlisting, little meat, yet were finely developed, and were sound when passed; still after the severe training, with a daily allowance of meat, beer, and vegetables, frequently and suddenly have acute tuberculosis. This he, and others, attribute entirely to the vitiated atmosphere in which the men sleep, the cubic space being small, the air saturated with emanations from the stables below, and from the men themselves, together with frequently a stinking urine tub, and the effluvia arising from the vomit of a drunken comrade, every ingress of fresh air being, perhaps, closed at the desire of an old soldier suffering from chronic bronchitis.

Dr. Purcell related a case of exostosis, removal from the femur, and union by first intention; specimen and cast.

Miss S. O—, æt. 17, sought advice on March 9th, 1877, for what she called a bone splint, situated on the inner surface of her right thigh. She first noticed some enlargement of the part about eleven years ago, which she supposed originated by a fall down a staircase. It advanced in growth very little until about six months ago, when, on rising quickly from the dinner-table, she struck it, which caused great pain. Soon after, when skating on a rink, she received a bad fall, bruising the tumour, which since increased. On examination, the tumour was found to be hard and irregular, about the size of an orange, situated on the upper portion of the lower third of the femur, and on its superior and internal aspect, causing no pain or hindrance to the movement of the muscles; the finger could define its size, but whether it had a small, or an extensive, attachment was uncertain. Removal was recommended, after consultation with Mr. William Adams, and accordingly on the 27th March, the patient being under ether, a semilunar incision was made through the integuments, about eight inches in length, over the tumour, to within three inches of the edge of the patella, cutting straight into the

mass, which was denuded of periosteum. Having passed the finger round the base, and finding all free, and that the attachment was not extensive, with a subcutaneeus bone-saw the base was cut through, and after removing any small *débris*, the wound was closed with silk sutures, and strapped with a pad of carbolised oiled lint. The leg and thigh, after being bandaged with a flannel roller, subsequently caused no trouble; the wound healed by the first intention, and thirteen days after the patient was out and about.

The cast, in plaster of Paris, was made just before the operation, showing the swelling, and its position. The tumour was ovoid in shape, the size of an orange, with nodules on the surface. On section it was found to be cancellous in parts, with chalky portions, hard at circumference, softish in its centre, presenting patches of cartilage with bone-like formations.

Mr. William Adams gave his reasons for recommending removal: —(1) On account of its rapid growth; (2) that it could be removed without interfering with any important structures, and it was single, no other tumours existing elsewhere. The union was somewhat unusual, and deserved notice; no washing out took place at the time of operation; no special septic arrangement was applied, as that of Lister's method, but yet the wound healed completely and rapidly. He congratulated Dr. Purcell on the success of his case.

Mr. Bloxam remarked that, in his opinion, the growth differed from an ordinary case of exostosis; in fact, he feared it might subsequently give trouble. No cartilage was present on the surface of the tumour; its internal structure was not truly cancellous. Cartilage with chalky formations was seen as in mixed enchondromatous tumours.

Mr. Adams read a case of strangulated femoral hernia, of which the following is the history:

J. B—, æt. 82, labourer, was admitted into the Great Northern Hospital, January 22nd, with the ordinary symptoms of strangulated hernia. The rupture, which has frequently come down, he has generally returned without much difficulty. In one or two cases he has failed in his attempt to do so, however, and has been obliged to call in a medical man for its reduction. The patient was unable to say how long the hernia had presented itself; he thought about three or four days. When admitted there was a tumour in the groin, situated below Poupart's ligament, not very tense, and about the

size of a small orange; there was distinct impulse on coughing. Taxis, after warm bath, was tried about 12 p.m., but without success; symptoms continued, and the operation took place early the next morning. May 23rd.—The sac was opened, and a large quantity of fluid escaped. On further examination it appeared that a thin layer of lymph was spread over a fold of intestine, presenting a smooth surface; so marked was this that several present were under the impression that the sac had not been opened. After tearing this, and separating the folds of the intestine, and subsequently dividing Gimbernat's ligament, the hernia was returned. All progressed favorably, except non-action of the bowels. Accordingly, on the 29th an enema of soap and castor oil was administered; a free evacuation followed. February 12th.—The wound appeared quite healed, and the patient was discharged.

Monday, April 23rd, 1877.

George Buchanan, M.D., F.R.C.P., President, in the Chair.

Dr. T. P. Lucas read a paper on

THE ACTION OF ALCOHOL ON THE ANIMAL ECONOMY.

The author took objection to the theory of vital force being elaborated in the muscular contraction, and took for analogy the steam-engine, urging that the force liberated in the combustion of fuel, passing as heat through the water, expanded it into steam, in which form, by the varied machinery, it was rendered available for the purposes intended. And so in the animal economy, the combustion of fuel, the disintegration and waste of tissue, the physical and chemical changes, friction in the circulation of corpuscles with each other and against the walls of the vessels, elaborates force as heat and electricity, which is appropriated by the nerve-centres and directed by nerve-fibres to every part of the body, the force exhibited producing various phenomena according to the mechanisms acted upon.

The two series of nerves, cerebro-spinal and vaso-motor, were next noticed. Stimulation, by galvanism, of the cerebro-spinal, produced exalted vitality; stimulation in a similar manner of the vaso-motor produced a lowered vitality. Certain medicines, as stimulants, raise vitality; others, as sedatives, depress vitality. It was philosophical, therefore, to conclude that the stimulants acted by means of the cerebro-spinal nerves, and that the sedatives influence the vaso-motor nerves. On conservative principles the two series of nerves are intimately connected, especially in the sympathetic system, and by reflex action on each other keep in equilibrium the functions of the body. This explains the apparent difference in the action of drugs dependent on their doses. A sedative in a small dose will depress the pulse, cause chills, cold creeps, and lassitude; in a somewhat larger dose, which would seriously depress by reflex action on the cerebro-spinal nerves, Nature strives to rid herself of the poison. Hence a reaction—fever. But if the dose be given large enough to overcome the contra-efforts of Nature, true narcotic poisoning and coma follow even to the loss of life. On the other hand, *local stimulants* produce redness, inflammation, and the sequelæ; *general stimulants* tone, stimulate, and exhaust, until the nerves, by electricity or life, are so far spent as to necessitate sleep for the safety of the patients.

Only a certain amount of nerve electricity is generated per minute; therefore only so much force can be manifested in a given time. If exalted currents are directed to any particular part of the body, the other parts are in a degree dormant; for instance, a man running cannot *think* deeply; the stomach is powerless in acute disease; large doses of alcohol are physiologically inert in fever. The author then brought forward several arguments to prove that alcohol burns within the system, partially displacing the fats or sugar used in natural combustion, the fats being retained in the tissues till needed. This combustion and the alcoholic exhaustion lowers the body-heat from 1° to 5°, the degree being in proportion to the exhaustion induced in previous health.

The action of alcohol in precipitating albumen was then referred to, and shown to exert no material influence on the body, either by precipitating pepsin, or in acting as an astringent. The alteration in the corpuscles, and deficient oxidation, was accounted for rather by indirect physiological action than by the direct chemical action upon them. Exhaustion and a lowered vitality are always

accompanied by an increase of carbonic acid in the blood, while at the same time the deficient supply of oxygen is proved by the darker colour of the corpuscle.

The general action of alcohol was next considered: its local stimulation on the part of the alimentary canal with which it comes into contact. This is but transient, causing a flow of the alimentary fluids, and thus creating appetite, but failing to keep the supply of gastric juice and other solvents, alcohol being a general stimulant. When absorbed into the circulation it directs the vital energy to other portions of the body, and so abstracts the supply from the stomach. Thus it induces an appetite, causes the person to eat a hearty meal, and then leaves the atomic stomach to do the best it can under the circumstances. Not a very scientific cure for indigestion! When absorbed into the general circulation it at first stimulates the local nerve-centres, but afterwards stimulates more especially the brain hemispheres, and parts supplied by the medulla. The excitation of local nerve-centres is rapidly followed by depression, the nerve energy being withdrawn and directed elsewhere. That alcohol is only useful as a remedy when a sudden spurt or excitation effects the object in view, notwithstanding the concomitant sequelæ; thus the first dose or so may relieve an atomic diarrhœa. In an accouchment a sudden stimulus may expel the fœtus. A strong dose of alcohol, with favouring circumstances, may induce perspiration, and thus throw off a cold. But if in such case relief be not instantaneous, the disease is at once aggravated and confirmed.

Alcohol in large doses exhausts and withdraws active vitality from nerve-centre after centre, until the legs, arms, abdominal viscera, and brain hemispheres, are dormant. This at first causes a lowered vitality, lassitude of body and mind, sleep (if the dose be sufficiently potent the sleep deepens into drunken sleep), and narcotism; a still more potent dose deepens the sleep, which often ends in death. Persons taking alcohol in cold climates, and who die in sleep therefrom, do so on account of the physical exhaustion and lowered temperature induced, and not because the alcohol drives the hot blood to the surface. If it simply effected this and *continued to do so*, the cold would not penetrate, even as a fire in a greenhouse radiates heat and keeps out cold. It is the lowered vitality and the letting in of cold that induces sleep and death. The theory that alcohol paralyses the vaso-motor centres, and so causes heat and

flushing, was warmly combated. Paralysis of a nerve means a previously exalted condition of that nerve. If alcohol paralysed these depressor nerves we should get rigors, lowered circulation, cold sweats, &c., but we do *not*. It is far more philosophical to allow that the alcohol directly stimulates the cerebro-spinal nerves, even as running and other exciting causes do. Alcohol as a food and as a medicine was then briefly noticed, and the author concluded his paper by giving the two following maxims :

1st. To prescribe alcohol alone, or in combination with other medicines, in proper doses, is scientific and philosophical, nor can it lead to harm.

2nd. To order and compel patients to partake of adulterated alcoholic elixirs, and of unknown strength, and for the most part at their own discretion, is unscientific, unphilosophical, and dangerous.

Dr. Edmunds then expressed his theory of alcohol causing fatty degeneration. He thought Dr. Lucas' paper might have been condensed, and as to many of his ideas on alcohol and its action, he denied them *in toto*.

Dr. Drew asked Dr. Lucas what he meant by the term "nerve electricity." He could not agree with Dr. Edmunds as to alcohol holding fatty matters in solution, as in the most common forms of fatty degeneration it occurs in the tissue itself, and leads to decrease in its size.

Dr. Edmunds answered the question, and said he quite followed Dr. Drew in his notions; he rather alluded to fatty deposition than fatty degeneration in the tissue.

Dr. Fothergill said he objected, and could not accept some of Dr. Lucas' experiments, especially that where a rabbit had been injected with $\frac{1}{100}$th grain of strychnine, and yet lived. He had found it the opposite; in fact, they could not bear anything like the dose mentioned.

Dr. Lucas, in reply, said that he did not know that alcohol served as a solvent in the circulation, considering what a small quantity was ever present at one time. What he meant by the term "nerve electricity" was that force or current that ran along the nerves from the centres to the periphery.

The President thanked Dr. Lucas for the great pains and trouble he had taken to produce his paper, but insisted on the importance of actual physiological and clinical experience before all in settling the questions that had been raised. Referring to a certain

class of arguments that had been used by the author, he would ask the Society, as concerned alike with men's bodies and minds, to avoid exalting the one at the expense of the other. He quoted, in illustration of his caution, from Edmund Burke, in 'A Vindication of Natural Society :'—" Many things have been said, and very well, undoubtedly, on the subjection in which we should preserve our bodies to the government of our understanding ; but enough has not been said upon the restraint which our bodily necessities ought to lay on the extravagant sublimities and eccentric rovings of our minds. The body, or, as some love to call it, our inferior nature, is wiser in its own plain way, and attends its own business more directly than the mind with all its boasted subtlety."

Monday, April 30th, 1877.

George Buchanan, M.D., F.R.C.P., President, in the Chair.

Dr. Percy Boulton read a short paper on

CHRONIC INFLAMMATION AND ULCERATION OF THE OS AND CERVIX UTERI.

He was led to bring the subject before the Society by reading some remarks in a book written by Dr. Madden, of Dublin, entitled 'The Health Resorts of Europe.' In this, Dr. Madden says,—" With regard to active local treatment in ordinary cases of chronic inflammation and simple ulceration of the os and cervix uteri, if we trusted more to constitutional remedies and, above all, to the judicious employment of certain mineral waters in such cases, I verily believe that in many instances our patients would get well sooner than they do when the local irritation is increased, secundum artem, by frequent examinations, and the repeated application of escharotics."

This was so entirely opposed to the views of Dr. Boulton that he brought the matter forward, in order to advocate local, rather than constitutional treatment.

He looked upon a considerable number of the cases which came under his observation in the out-door department of the Samaritan

Hospital, and in his private practice, as the failures of the *constitutional* practitioners. The patients say that for months or, perhaps, years, they have suffered from weariness, debility, backache, and discomfort, and have taken tonics without any results. Some of them have undergone a vaginal examination, and been ordered a lotion, which they have injected daily, (probably with a small glass syringe), without benefit.

The author was convinced that constitutional treatment alone rarely succeeds, while local treatment properly carried out always does. In his hospital practice he found that the worst cases recovered in three months, after about twelve applications.

He was at the present time treating two private patients, who spent all last autumn at Kreuznach, and were drenched from morning to night with foul tasting waters, and ascending douches and baths, without the least benefit, and he had seen dozens of such cases.

What will cure the poor will cure the rich, and the former could not afford the mineral water treatment, but luckily they do not require it, local treatment at home being sufficient.

Accurately applied remedies to the diseased part, and judicious choice of them, according to the stage of the disease, is surely good common sense. Generally there is a good deal of very tenacious white-of-egg discharge, which requires wiping thoroughly away before any application is made. Any one that knows the very obstinate way in which this clings to the cervix must be aware that no ordinary douche would remove it, and therefore no lotion could reach the diseased surface. This discharge is often a cause of sterility by corking up, as it were, the uterus.

"When the local irritation is increased by the application of escharotics," it is not the local treatment that is wrong, but the choice of escharotic; caustics, when too strong or too frequently applied, may and do increase the local irritation; a great deal of the success depends on the proper selection of remedies. As the cases are chronic the time has generally passed for leeching or scarification, which, in their proper places, are most valuable remedies, and, perhaps, even now scarification, if properly and thoroughly done. When the uterus is highly congested and angry, some four or six punctures, half an inch deep, into the cervix round the os uteri does wonders. In a few minutes one or two ounces of blood may be safely taken from the engorged womb with good results. The lancet must always be pushed in parallel with the cervical canal.

Strong caustics often do more harm than good. Even nitric acid and acid nitrate of mercury, two most excellent and valuable applications, should be used with some caution. The indications for these remedies are a very patulous os uteri, and a chronic indolent condition. In subinvolution they are excellent remedies, but both occasionally set up sympathetic dysentery, and consequently they should be used with great caution in out-door hospital practice, where, as a rule, the patients have to walk home. Both these remedies are more potent than nitrate of silver, which may be employed with greater freedom.

In cases where there is a hypertrophied and indurated lip it is sometimes necessary to make an issue before sufficient interstitial absorption can be aroused to effect a cure. Instead of Potassa c̄ Calce, or stick caustic potash, the new (Paquelin's) thermo cautery is a clean, handy, safe, and efficient means. An eschar can be speedily made of the desired depth, without any of the chances of vaginal excoriation, which is a possible contingency when the potassa is used. In a simple case of chronic inflammation and ulceration these things are not necessary. After wiping the ulcer clean with cotton-wool, the application of solid nitrate of silver should be persevered with till it is nearly healed, when a solution of nitrate of silver, ʒj to ℥j, is, perhaps, better than the solid. When the surface is quite covered with mucous membrane there may be still a thin persistent discharge, and for this a simple astringent, such as perchloride of iron (ʒj of the solid to ℥j of water), is a capital remedy.

Churchill's strong tincture of iodine, and carbolate of glycerine of double the pharmacopœial strength, are useful remedies for occasional application. The glycerine tampon or plug of cotton-wool, applied through the speculum to the os uteri, is at times very useful. It sets up a copious serous discharge, which relieves the uterus. Such local remedies the author believed capable of curing almost any case of chronic inflammation and ulceration of the os and cervix.

That certain constitutional remedies are of great value he was convinced, but that it is the local and not the constitutional remedies which are all important is shewn by this, that if the local treatment be neglected the cases always go back, while so long as the applications are regularly made they progress.

After enumerating the medicines he was in the habit of prescribing, the author remarked that rest in the recumbent posture

should be always, as far as possible, enjoined, and physiological rest recommended.

Dr. Routh said that after an experience of thirty-five years in the treatment of these cases the main points of Dr. Boulton's paper met with his entire approval. In reference to the examination of virgins, he had been able to dilate the hymen, thus admitting of an examination of the os without the destruction of the membrane; subsequently the parts returned to their normal condition. He was rather adverse to the use of nitrate of silver, as under his hands it had not been so efficacious as the author stated. He found the best results follow the use of sponge-tents.

Dr. Heywood Smith said he differed from the author in many points. (1) All ulcerations of the os were not of the same nature, and he thought that the title of the paper was wide. He should like to have heard what distinct ulceration the author intended to treat; for he said we have syphilitic ulcer of the os, rodent ulcer, strumous ulcer, slight artificial ulceration, and the red granular os uteri, which, he supposed, was the ulceration the author especially directed attention to. He considered it most important to direct attention to constitutional treatment in these varieties; although he was fully alive to the advantages of local treatment, yet he would not trust to that alone, but to the combination of both.

Dr. Godson said he had found good results follow leeching the anus in this disease when occurring in virgins.

Dr. Boyd then read a paper on the

RESULTS OF TREATING PATIENTS AT THEIR OWN HOMES AS CONTRASTED WITH THOSE OBTAINED IN INFIRMARIES.

In this paper Dr. Boyd related his experiences of treating patients for a period of three years at their own homes, in the parish of Marylebone, contrasting the results with those obtained in the infirmary of the same parish during the same years. The writer's experience corresponded with the views entertained by Sir James Simpson.

The paper was in great measure intended to support the views of Sir Charles Trevelyan, expounded in a paper read before the Charity Organisation Society on the 17th of April last, in which that author, from a social point of view, treated most fully of the question of

medical relief, showing that the hospital system tended to pauperise the population, the immunity from all inquiries as to their means, and the capabilities of their families to support them, inducing persons most unfitted for charitable relief to apply for and obtain such relief from the public hospitals. As an alternative Sir Charles advocated the establishment of provident dispensaries, as being well calculated to encourage habits of economy and a spirit of independence amongst the poorer classes.

Dr. Boyd now treated the same question from a medical point of view, and referred to statistics published by him in the 'Lancet' and 'Edinburgh Med. and Surg. Journal' as far back as 1842. The experience of the writer, as set down in these statistics, went to show that not only were provident dispensaries, or analogous institutions, desirable for the social and moral well being of the poor, but that they were equally beneficial from a medical point of view, it being a well-established fact that, though at first sight it might appear somewhat incomprehensible, patients derive more benefit from medical treatment in their own homes than from that which they receive in hospitals.

An analysis of the statistical tables showed the results obtained by treatment in 13,364 cases. Of these, 7179 were treated at their own homes and 6185 in the infirmary, the number of recoveries in the latter case being considerably greater than in the former, notwithstanding the unfavorable hygienic conditions of the patients' own homes in a poor and crowded neighbourhood. In all cases similar diseases were placed side by side for comparison, the table showing a percentage of deaths amounting to 7 in cases treated at home, as against 15 per cent. in those treated at the infirmary. The patients attended at their own homes were by no means those afflicted only with slight diseases, but for the most part they were very seriously ill and confined to bed, and in many cases suffering from some acute disease, and refusing to go into the infirmary, as they preferred to remain with their families. In the table, to make the results in all respects comparable, the cases were not only classified according to their diseases, but also in respect of age and sex, the time of year being likewise taken into account. These experiences, which quite correspond with those of Sir James Simpson, would seem to be in great measure explicable by the influence which the surroundings of a hospital have on the spirits of the inmates. In many instances the removal of a patient from home,

separating him from his family, and placing him in a hospital amongst strangers, many, perhaps, in a dying state, cannot but have a very depressing effect, and add materially to the mortality of such institutions.

The writer concluded by observing that in all respects—social, moral, and physical—was home attendance more desirable than the hospital system, more especially as the rapidly improving hygienic conditions of the dwellings of the poor cannot but make us look even more hopefully towards such treatment in the future. Nor is it only on the patients themselves that such a system would act beneficially, but also on their families, teaching them that they have duties to perform towards their sick and dying relatives, and that it is inconsistent with such duties to rid themselves of them as quickly as may be. These remarks could obviously only be applicable to patients who had homes and relatives, and the value of hospitals, in affording relief to true objects of charity for the treatment of contagious diseases and the insane, and as means of clinical instruction, was by no means to be underrated.

May 7th, 1877.

The Annual Oration was delivered by Dr. J. Hughlings Jackson:

Subject.—"OPHTHALMOLOGY AND GENERAL MEDICINE."

At the conclusion a vote of thanks was proposed, and carried by acclamation.

The usual Conversazione followed, which was numerously attended, and brought the 104th Session to a termination.

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